

VOLUME FOUR

NUMBER NINE

*the*

# Journal

*of the association for physical  
and mental rehabilitation*

**CONVENTION  
ISSUE**

**LOS ANGELES, CALIFORNIA**

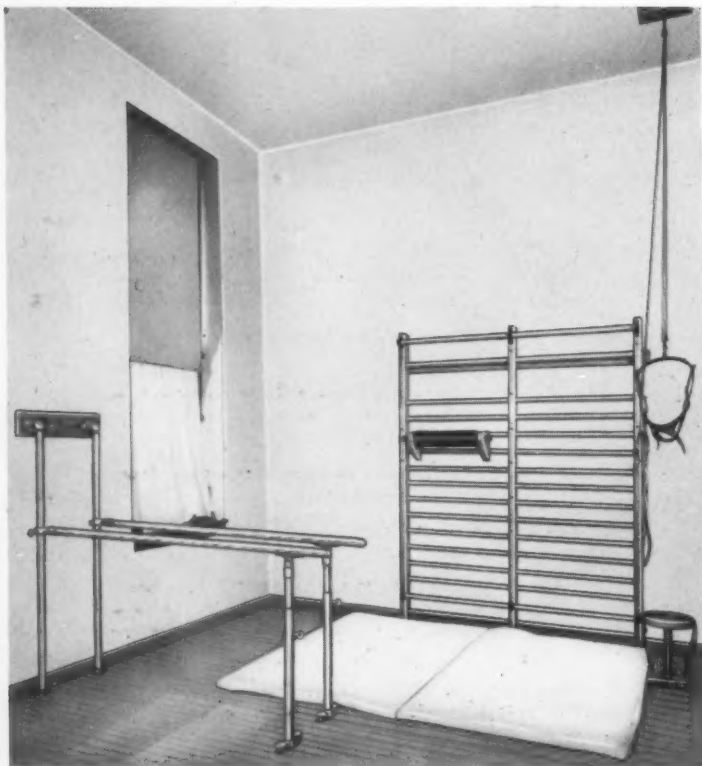
**JULY 3, 4, 5, 6—1951**



**JUNE - JULY**

**1951**

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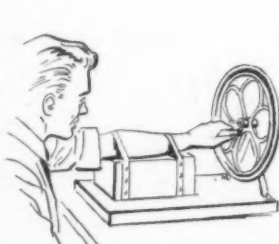
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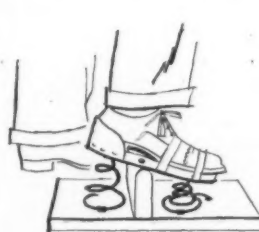
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PHYSICAL and MENTAL  
REHABILITATION  
Published Bi-Monthly

Volume 4

Number 9

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# OFFICIAL PROGRAM

## FIFTH ANNUAL SCIENTIFIC AND CLINICAL CONFERENCE

### ASSOCIATION FOR PHYSICAL AND MENTAL REHABILITATION

#### HOTEL HOLLYWOOD ROOSEVELT — JULY 3, 4, 5, 6, 1951

#### TUESDAY—July 3

8:30 a.m.—8:00 p.m., Registration, Mezzanine.  
 8:00 a.m.—9:00 a.m., Problem Session, Room B.  
 9:00 a.m.—10:00 a.m., Executive Board, Room B.  
 10:00 a.m.—12:00 Noon, Executive Board and Rep. Assembly, Room B.  
 1:00 p.m.—4:00 p.m., Executive Board and Rep. Assembly, Room B.  
 7:30 p.m.—9:00 p.m., Movie "The Men," Aviation Room.

#### WEDNESDAY—July 4

7:30 a.m.—8:45 a.m., Past President's Breakfast.  
 8:00 a.m.—5:00 p.m., Registration—Exhibits.  
 8:15 a.m.—8:45 a.m., Movie "Cineplasty," Room B

#### GENERAL ASSEMBLY

##### MORNING SESSION: Blossom Room

Presiding: Wilbur A. Selle, Ph. D., Professor of Biophysics and Acting Chairman of Physiology, U.C.L.A. Medical School, Los Angeles, California.  
 9:00 a.m.—9:30 a.m.  
 Invocation: Dr. Ernest C. Wilson, Minister, Christ Church Unity, Hollywood, California.  
 Welcome: Col. Robert A. Bringham, Manager, V. A. Center, West Los Angeles, California.  
 Response: George V. Devins, President.  
 9:30 a.m.—10:15 a.m.  
 "The Effect of Cortisone in Myotonia Atrophica," Ralph W. Barris, M.D., Chief, Neurology Service, Veterans Administration, General Medical and Surgical Hospital, Los Angeles, California, and Harvey Strassman, M.D., Veterans Administration, Los Angeles, California.  
 10:20 a.m.—11:30 a.m.  
 "Neuro-Muscular Facilitation," Herman Kabat, M.D., Medical Director, Kabat-Kaiser Institute, Vallejo, California.  
 11:30 a.m.—1:00 p.m., Lunch.

##### AFTERNOON SESSION: Blossom Room

Presiding: Roy H. Nyquist, M.D., Acting Chief, Physical Medicine and Rehabilitation Service, Veterans Administration Hospital, Long Beach, California.  
 1:00 p.m.—1:30 p.m.  
 "Influence of Heat and Cold on Peripheral Circulation," Theodore B. Massell, M.D., Vascular Surgeon, Los Angeles, California.  
 1:30 p.m.—2:00 p.m.  
 "Psychology of Disablement," Gerald L. Goodstone, M.D., Chief, Physical Medicine and Rehabilitation Service, Veterans Administration Neuropsychiatric Hospital, West Los Angeles, California.  
 2:05 p.m.—4:00 p.m.  
 Multiple Sclerosis Symposium  
 2:05 p.m.—2:10 p.m.  
 "Introduction to Multiple Sclerosis," John H. Aldes, M.D., Director, Rehabilitation and Physical Medicine, Cedars of Lebanon Hospital, Los Angeles, California.  
 2:05 p.m.—2:30 p.m.  
 "The Function of the National Society of Multiple Sclerosis," J. J. Karpeles, M.D., President of the Multiple Sclerosis Society.  
 2:30 p.m.—3:00 p.m.  
 "Neurological Aspects of Multiple Sclerosis," Tracy J. Putnam, M.D., Chief, Neurological Department, Cedars of Lebanon Hospital, Los Angeles, California; Professor of Neurology and Neurological Surgery, Columbia University, New York, New York.  
 3:00 p.m.—3:30 p.m.  
 "Psychological Aspects of Multiple Sclerosis," Philip Solomon, M.D., Neurological Department, Cedars of Lebanon Hospital, Los Angeles, California.  
 3:30 p.m.—4:00 p.m.  
 "Rehabilitation for Multiple Sclerosis," O. Leonard Huddleston, M.D., Medical Director, Kabat-Kaiser Institute, Santa Monica, California.

#### THURSDAY—July 5

8:30 a.m.—5:00 p.m., Registration—Exhibits, Mezzanine  
 8:15 a.m.—8:45 a.m., Movie "Activity For Schizophrenia"

##### MORNING SESSION: Blossom Room

Presiding: Carl Haven Young, Ph.D., Chairman, Physical Education Department, University of California, Los Angeles, California.  
 9:00 a.m.—9:30 a.m.  
 "Acute Intensive Treatment Program For The Neuropsychiatric Patient," Samuel Wick, M.D., Chief, Intensive Treatment Service, Veterans Administration, Neuropsychiatric Hospital, West Los Angeles, California.  
 9:35 a.m.—10:00 a.m.  
 "Motor Aspects of Anxiety State," Solon D. Samuels, M.D., Staff Psychiatrist, Veterans Administration Neuropsychiatric Hospital; Consultant Psychiatrist, Domiciliary Unit, Veterans Administration Center, West Los Angeles, California.  
 10:00 a.m.—10:30 a.m.  
 "Fascia Stretching," Harvey E. Billig, Jr., M.D., F.I.C.S. Medical Director, Billig Clinic for Rehabilitation, Professor of Physical Rehabilitation, Pepperdine College, Los Angeles, California.  
 10:35 a.m.—11:30 a.m.  
 "Some Aspects of Relaxation," Eleanor Metheny, Ph.D., Professor of Education and Physical Education, University of Southern California, Los Angeles, California.  
 11:30 a.m.—12:00 Noon  
 Movie "Fascia Stretching"—to be introduced by Dr. Harvey Billig.  
 12:00 Noon—1:00 p.m., Lunch

##### AFTERNOON SESSION: Blossom Room

Presiding: Robert Mazet, Jr., M.D., Chief, Orthopedic Service, Veterans Administration, General Medical and Surgical Hospital, Los Angeles, California.  
 1:00 p.m.—2:00 p.m.  
 "Adolescence of Corrective Therapy," John E. Davis, M.A., Sc.D., Chief, Corrective Therapy, Central Office, Veterans Administration, Washington, D. C.  
 2:05 p.m.—4:00 p.m.  
 "Upper and Lower Extremity Amputees"  
 2:05 p.m.—2:35 p.m.  
 "Surgery on Upper and Lower Amputees," John H. Aldes, M.D., Director, Rehabilitation and Physical Medicine, Cedars of Lebanon Hospital, Hollywood, California.  
 2:35 p.m.—3:00 p.m.  
 "Prothesis," Edward F. Ruzika, Chief of Prothesis and Sensory Aids Unit, Veterans Administration, Regional Office, Los Angeles, California.  
 3:00 p.m.—3:30 p.m.  
 "Rehabilitation of the Amputee," Thomas F. Barrett, M.D., Chief, Professional Services, Veterans Administration General Medical and Surgical Hospital, Los Angeles, California.  
 3:30 p.m.—4:00 p.m.  
 "Psychological Findings in the Rehabilitation of the Amputees," Morse P. Manson, Ph.D., Chief, Vocational Rehabilitation and Education, Veterans Administration Hospital, Long Beach, California.  
 4:05 p.m.—4:30 p.m.  
 "Rehabilitation of the Hemiplegic," Leonard J. Yamshon, M.D., Chief, Physical Medicine and Rehabilitation, Mount Sinai Hospital, Los Angeles, California.  
 4:30 p.m.—5:00 p.m.  
 "National Trends in Rehabilitation," Robert N. McCurdy, Chairman, National Rehabilitation Committee, The American Legion, Pasadena, California.

##### EVENING SESSION: Blossom Room

8:00 p.m.  
 Banquet. Key Speaker, Stafford L. Warren, M.D., Dean



of the Medical School, University of California, Los Angeles, California.

#### FRIDAY—July 6

8:00 a.m.—9:00 a.m.

Meeting of Executive Board and Representative Assembly, Room B.

8:15 a.m.—8:45 a.m.

Movie, "Aphasia."

8:30 a.m.—5:00 p.m.

Registration—Exhibits, Mezzanine.

7:00 p.m.—10:00 p.m.

Meeting of Chiefs and Executive Assistants of Physical Medicine and Rehabilitation, Room B.

7:00 p.m.—10:00 p.m.

Meeting of Educational and Manual Arts Therapists, Room A.

7:00 p.m.—10:00 p.m.

Meeting of Active Members, Aviation Room.

#### MORNING SESSION: Blossom Room

Presiding: David G. Shaw, Medical Rehabilitation Field Supervisor, Veterans Administration Area Office, San Francisco, California.

9:00 a.m.—9:45 a.m.

"Stretch Reflex", Horace Magoun, M.D., Professor and Chairman of Anatomy Department, School of Medicine, University of California, Los Angeles, California.

9:50 a.m.—10:30 a.m.

"Disabilities of the Back and Their Corrections", Joseph C. Risser, M.D., Orthopedic Surgeon, Pasadena, California.

10:35 a.m.—10:45 a.m.

Introduction, John E. Davis, M.D., Sc.D., Chief, Corrective Therapy, Central Office, Veterans Administration, Washington, D. C.

10:45 a.m.—11:30 a.m.

"Corrective Therapy for the Catatonic Patient", Paul Roland, Chief, Corrective Therapy, Veterans Ad-

ministration Hospital, Danville, Illinois.

11:30 a.m.—1:00 p.m., Lunch

#### AFTERNOON SESSION: Blossom Room

Presiding: Robert V. Miller, M.D., Chief, Physical Medicine and Rehabilitation, Veterans Administration General Medical and Surgical Hospital, Los Angeles, California.

1:00 p.m.—1:30 p.m.

"Therapeutic Conversation", David Grossman, Ph.D., Co-Director, Los Angeles Psychological Service Center, Los Angeles, California.

1:35 p.m.—2:30 p.m.

"Psychodynamic Aspects of the Kinetic Approach to Catatonic Patients", James H. Rankin, M.D., Chief, Professional Service, Veterans Administration Neuropsychiatric Hospital, West Los Angeles, California.

2:35 p.m.—5:00 p.m.

"Panel on Polio."

2:35 p.m.—3:15 p.m.

"Guidance of Patients Through Acute Stages of Poliomyelitis and Their Orientation for Rehabilitation", E. W. Fowlks, M.D., Chief, Physical Medicine Rehabilitation Service, Veterans Administration Hospital, Portland, Oregon.

3:20 p.m.—3:40 p.m.

"Nursing Care of Poliomyelitis Patients," Miss Vivian Anderson, R.N., Charge Nurse, Poliomyelitis Unit, Veterans Administration Hospital, Long Beach, California.

3:45 p.m.—4:05 p.m.

"Social Service in Poliomyelitis", Mrs. Doris Bernhagen, Director, Student Training, Neuromedical Social Service Work, Los Angeles County Department of Charity, Los Angeles, California.

4:10 p.m.—5:00 p.m.

"Rehabilitation of the Poliomyelitis Patient", J. Sloan Berryman, M.D., Veterans Administration Hospital, Long Beach, California.



Meet the hard-working Chairman of our 1951 National Convention—Burr S. Zachary, Chief, Corrective Therapy at the Neuropsychiatric Hospital in sunny Los Angeles, California. From all reports Mr. Zachary is planning an outstanding convention that will include recognized experts from all specialties in Rehabilitation and following each day's program a

social activities list that will make you want to have every convention in Los Angeles and each year's chairman Burr Zachary.

Before his assignment to the Veterans Administration in 1946, he was Physical Rehabilitation Officer at the Naval Hospital at Bremerton, Washington, where he was responsible for a program that served the needs of over 300 naval patients. Prior to that, "Zac" was Physical Rehabilitation Officer in the neuropsychiatric unit of the Naval Hospital at San Diego, California and also at the Naval Hospital, Great Lakes, Illinois. His years of experience in hospitals of all types with patient loads of over 3000 and a staff of over 1000 have made him a recognized leader on the West Coast in the field of recreation and exercise therapy.

Before Pearl Harbor, "Zac" spent several years coaching sports of all kinds and remembers with pride his friends at North Texas State Teachers College Demonstration School, where he was Assistant Physical Education Director. "Zac" got his degree from North Texas State Teachers College in the field of physical education. "Zac" is now pursuing graduate studies at the University of Southern California.

So when you get to Hollywood, California, this July 3 thru 6, be sure to see our Convention Chairman, Burr Zachary, for the best tips of what to do and where to go in Southern California.

## Your Home for the Fifth Annual National Convention

The Corrective Therapists in Southern California, under the guidance of Mr. Burr S. Zachary as Convention Chairman, are planning to make your visit to the Fifth National Convention as fun-packed and as Hollywoodish as possible, while at the same time the program committee is carrying out its plans to present a well-rounded, high caliber professional and scientific program.

All of you will be housed either in the Hollywood Roosevelt Hotel or in spots quite close to the meeting place. The Hollywood Roosevelt Hotel is one of the outstanding show places in the country, featuring a million-dollar swimming pool and linai, surrounded by rooms with private outdoor living areas. There is dancing nightly in the Cine Grill with two great name bands and where stage, screen and radio celebrities, and corrective therapists may be seen in great numbers . . . and the hotel rates are reasonable, too!

July in Southern California is something you will not want to miss. The tropical plants, the ideal weather, and the fact that the Hollywood Roosevelt Hotel is in the very heart of the radio, television and film industry will assure you of a vacation you will never forget.

Mr. Zachary has appointed a number of committees to make the convention, not only a professional success, but a social success as well. A special committee has been appointed to plan all kinds of entertainment for your wives while you are being "educated." There will be many unusual opportunities for visits to a motion picture studio, television industry, swimming at the beach, etc., so why not be wise and plan your summer vacation to coincide with the national convention?

Bring your wife and family to Los Angeles in Southern California this July. We are expecting you!

B. M. REINHARDT  
Publicity Chairman  
5th Annual CT Convention

### REGISTRATION:

Registration will begin at 8:30 A.M. on Tuesday, July 3, 1951, and will continue through Friday, July 6, 1951. The Registration Desk is located on the Mezzanine. The registration fee of \$10.00 includes the banquet and attendance at all meetings. For those desiring to attend one session only, the fee is as follows: One-half day (one session)—\$1.50; Student tickets for all sessions, \$.50; Banquet tickets, \$4.50.

### ENTERTAINMENT:

The Reception Committee will have information at the Information Desk regarding the various forms of entertainment available in Southern California.

### BADGES:

All members, visitors, and guests will be required to wear the official convention badge or present the single session registration ticket for admission to all sessions.

### HOTEL RESERVATIONS:

Anyone desiring hotel accommodations may contact the Registration Committee at the Registration Desk. It is desired that reservations be made in advance by sending in the form which appears in the Journal or Newsletter to Mr. Fred O'Banion, 6624 Peach Avenue, Van Nuys, California.

### RECEPTION COMMITTEE: (for wives)

Special attention to the wives who are contemplating coming to California with their husbands for the convention. Since extensive plans are being made to make your visit enjoyable, it is necessary to know how many of you will attend before final plans can be made. If there is a possibility that you will be here during the convention, it is requested that you drop a card to Mrs. Burr S. Zachary, 2527 Washington Avenue, Santa Monica, California. Upon your arrival please stop at the convention Registration Desk at the Hollywood Hotel for information relative to our plans for you.

### MEMBERSHIP:

The membership desk will be open from the morning of July 3, 1951, throughout the convention. The convention Membership Committee, consisting of Harold J. Brenner, Chairman, Richard Fowler, Clint Rankin and Harlan Wood, will be at the desk to accept your membership or renewal and welcome you as a member of the Association for Physical and Mental Rehabilitation.

Annual Dues: Active Membership (a degree in Physical Education and one year's experience under the direct supervision of a doctor of medicine)—\$6.00 per year with an initiation fee of \$1.00 for new members.  
Associate and Auxiliary Membership—\$4.00 per year.  
All memberships include a subscription to the Journal.

### JOIN NOW!

A National Directory will be available at the Membership Desk.

### PROGRAM:

Mimeographed official program will be mailed to all members in the near future. Printed official programs will be available at the Registration Desk.

# PHYSICAL CAPACITY APPRAISAL IN THE DETERMINATION OF FEASIBILITY FOR VOCATIONAL ACTIVITY

By BERNARD D. DAITZ  
Director, Tuberculosis Rehabilitation  
Veterans Administration  
Washington, D. C.

Lord Horder is reputed to have commented upon the confusion which exists in some areas of rehabilitation with the statement, "Reconditioning and rehabilitation are in the air; with many folk who pay lip service to these ideas, they remain in the air."<sup>1</sup> Those of us who have followed the progress of the physically impaired individual through his slow and uncertain experiences in the rehabilitation process toward its ultimate goal, productive employment, can well appreciate the appropriateness of Horder's remark. Not a little of the frustration and uncertainty experienced is related to the complex physiological problem of testing physical fitness.

Such terms as *work tolerance*, *work capacity*, *physical capacity*, and *medical feasibility* are well known to all of us; their precise meaning, however, is obscure. They presume to express the ability of the handicapped person to engage in physical activity . . . work . . . a job. Rarely, though, are these expressions qualified to suggest specifically the *kind* of activity for which the patient has *tolerance* or *capacity*, or how much of this activity the patient may safely undertake.

In many instances, evaluation of *work tolerance* has been made on the basis of walking exercise. Other tests of physical efficiency and fitness have been suggested.<sup>2,3</sup> Tegner<sup>4</sup> has stated that there is no simple test which can adequately reflect the cardiac, respiratory, and psychological factors which are involved in the appraisal of physical fitness. It is entirely possible that one day we will discover the basic physiologic factors which will lend themselves to quantitative measurement. Meanwhile, it is not surprising that many patients with residual disability such as we find in tuberculosis, heart disease and epilepsy, to mention a few of the disabling diseases, are discharged from the hospital and return home without an understanding of their disability and even less of their residual capacity. They *do* know that they must "take it easy," but such a prescription is far from being a measurable constant.

Such ex-patients are problems to themselves, to their families, to rehabilitation workers who can form no valid opinions as to the degree of residual capacity which the patient may have, and to the prospective employer who cannot be expected to hire someone who is physically impaired and whose physical capabilities are unknown. Here we have the necessary ingredients for failure in the rehabilitation process.

This is the problem or at least one of the problems for which some of us concerned with the Physical Medicine and Rehabilitation Program in the Veterans Administration have been attempting to find answers.

Our first discovery was that any evaluation of physical capacity was meaningless unless based upon the study of not only vocational activity but *all* the activity in which the patient engages during a twenty-four-hour day. Not long ago I was an interested observer sitting in on a rehabilitation case conference. The patient whose history was being reviewed was being treated for tuberculosis. The various members of the hospital staff who had been working with the patient reported on the specific therapeutic measures which they had been responsible for carrying out. Each stated the amount of time the patient had spent daily in the particular therapy. Impressed by the amount of physical activity in which the patient was obviously participating, I innocently inquired whether anyone could tell me how much time the patient was out of bed. I was not surprised at the puzzlement which I apparently created. No one had been looking at it just that way, and I therefore seized upon the opportunity to explain that an appraisal of physical capacity must include consideration of four classes of activity:

1. Self-Care (which includes dressing, grooming, bathing, eating).
2. Recreation (including participation in active or passive forms of leisure-time activities, movies, games, sports, hobby crafts).
3. Vocational (involving activity which is directed toward productive employment or organized study).
4. Sleep and Rest.

The average normal person if he is gainfully employed spends approximately ten hours at his job and getting to and from it. Self-care activities require approximately three hours daily. Sleep and rest, about eight hours, leaving three hours for recreation.

This is the framework upon which we can construct our physical capacity appraisal. It is a dynamic and practical technique. It can be varied by the physician to suit the particular interests of the patient, thus providing the necessary motivation and, equally important, furnishing the means for helping the patient to obtain an understanding of the meaning of activity. Because the activities can be varied in type, amount and intensity, increasing or decreasing the various elements as required, the physician



## PHYSICAL CAPACITY APPRAISAL IN THE DETERMINATION OF FEASIBILITY FOR VOCATIONAL ACTIVITY

can utilize this technique as a reconditioning measure, as well as for the appraisal of physical capacity.

A few illustrations may be helpful: The bedfast patient who is acutely ill is generally limited in the amount of physical and mental activity which he can undertake. More often than not, he is not interested in doing anything. As his condition improves, he becomes more aware of his surroundings, time begins to have some meaning, his appetite improves, he finds himself able to feed himself, read the newspaper and listen to the radio. Thus, we have the patient engaging in self-care and recreation, activities which involve physical as well as mental effort . . . work.

Steadily the patient's condition improves, he is permitted to get out of bed, have his meals sitting up and out of bed, and even to take a short walk around the room or into the corridor. He is doing more, but essentially in the self-care and recreation categories of our classification.

Up to this point, no special equipment is required. Nor is there anything strange or novel about the activities. This does not require some qualification. Special functional training and appraisal procedures have been developed for the orthopedically impaired patient, the hemiplegic, paraplegic, quadriplegic, the patient with residuals of poliomyelitis, the amputee and the cerebral palsied.<sup>5,6</sup> These are of course concerned with therapy and evaluation of motor activity. On the other hand, treatment and appraisal of the cardiac and the tuberculous patient must be related to the effects of metabolic demand.

It is in the area of testing physical capacity for vocational activity that difficulties are encountered. One important reason is that in too many instances a realistic rehabilitation objective is never established or its formulation is delayed too long. Without some idea as to the goal towards which the rehabilitation process is to be directed, positive and purposeful measures cannot be initiated.

The second reason for difficulty lies in the problem of providing vocational activity in a hospital or clinic setting. Here the matter of expense is an important factor. If we attempt to follow the principle of setting up realistic industrial processes, we can immediately expect that an infinite variety of equipment will be needed, as well as therapist personnel who are qualified to guide the patients in the details of its operation. Space also becomes a problem.

In the development of the Manual Arts Therapy Program in the hospitals of the Veterans Administration, the difficulties which I have mentioned soon become apparent. The Light Mechanics Procedure<sup>7</sup> is the result of our efforts to develop a standard set

of industrial operations which can be carried on within a hospital or clinic, providing a wide range of job situations with a minimum of equipment, material and personnel.

As its title implies, the Light Mechanics Procedure is designed to include the basic industrial processes which are generally found in manufacturing small tools, instruments, gauges, electrical appliances, toys, firearms and similar products. It also covers repair and adjustment operations. In developing the various job units which comprise the Light Mechanics Procedure, careful study was made of the physical demands which were found to be inherent in each of the operations. In this way we were able to standardize the job units as well as the physical demands which were involved.

The Light Mechanics Procedure consists of four parts. Part I is the Preliminary Job Series. This is used primarily for screening, for it not only enables the therapist to determine whether or not the patient possesses the aptitude for this type of work but the two jobs which comprise this job series involve all the physical demands which will be encountered in each of the other jobs which make up the Light Mechanics Procedure. For the entire series, the physical demands are relatively constant. The variables are participation time, rate of production and relative complexity of the jobs. With such standardization, it is obvious that both as conditioning therapy and appraisal, the Light Mechanics Procedure can provide practical job situations, permitting measurable increase in physical demands only with respect to participation time and production rate. In this way, it may be said that the patient who is able to spend four or six or eight hours at this work, over a reasonable period, maintaining a rate of production comparable to that expected in industry and showing steady improvement in his medical status, has the physical capacity for a like number of hours in any one of the large number of jobs in industry which have similar physical demands.

The first job in the Preliminary Job Series requires that the patient make a wire eye loop holder. Its purpose is to demonstrate the correct usage of certain types of pliers in forming wire. The operations involve the use of files to cut grooves across round wire stock, forming, bending and twisting wire stock, cutting stock with cutting pliers, and adjusting the eye loop holder. These operations are applicable to many jobs in various industries in which shaping and adjusting wire springs, connectors, and supports are involved. In order to be able to perform these operations, the patient must meet certain minimum physical demands requirements, such as being able to sit



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upright, have a minimum of 20/40 vision in each eye, with or without correction, have complete flexion of fingers, able to squeeze 60 pounds' pressure with one hand, be able to lift a 20-pound weight from the work bench drawer to the lathe bed. I cite these as examples, for the actual list of minimum physical demands is too lengthy to warrant further discussion and elaboration.

The second job of the Preliminary Unit involves working with round plates which have been drilled, tapped and counter-bored to receive tiny fillister-head screws. This job is designed to test the capacity of the patient for working with extremely small parts, and requires a great degree of fine muscular coordination. These activities are applicable to many phases of industry, both in the production line and in the small repair shop, which are concerned with the manufacture and repair of pressure gauges, electric meters, cameras, business machines, watches and optical equipment. The therapist in presenting this material to the patient ordinarily demonstrates the procedure to be followed, permitting the patient to use the instruction pamphlet for reference. The patient is then permitted to carry out the operations, with the primary emphasis placed on following the instructions relative to technique. Obviously, at first the patient will find that he must work slowly in order to achieve the end results. When he has completed each of the jobs, he may be asked to repeat the operations any number of times, first, to determine whether he can attain a rate of production approximately that in industry and, second, to increase the amount of his participation time. When the therapist has determined that he has the necessary information regarding the patient's capacity for this work, he may start the patient on Part II of the Light Mechanics Procedure, which is concerned with Precision Adjustment, or on Part III, which involves Precision Turning. The actual choice of one of these two series will depend largely on the patient's ultimate rehabilitation goal, as well as upon the interest and aptitudes which the patient has shown in the course of his work with the Preliminary Job Series.

The Precision Adjustment Job Series consists of six jobs and involves primarily hand adjustment work with very small tools and parts. The balance-wheel unit of a watch is used as the subject material, inasmuch as the principles which are involved are applicable to most mechanical wheel movements.

Time will not permit me to go into much more detail than this.

As regards the Precision Turning Job Series, the activities are designed to provide the patient an opportunity to perform work involving elementary

skills and knowledge peculiar to metal turning jobs. The work is, of course, basis to a wide variety of industries which are concerned with the manufacture of surgical instruments, knives, and tool and die making. There are seven jobs which comprise this series, ranging from sharpening hand gravers to the fabrication of an anchor bolt. As with the Preliminary Job Series, there are no set rules as to the number of times a patient must repeat any one of the jobs. This is a matter which is determined by the physician and the therapist, and is generally predicated upon the therapeutic purposes desired.

A few words may be appropriate at this time to emphasize the fact that neither the Light Mechanics Procedure nor any of the other activities comprising the Manual Arts Therapy or Educational Therapy Programs in our hospitals are directed at vocational training of patients. The primary purpose is therapy and evaluation. If, incidentally, the patient is able to learn a technique or acquire knowledge in a particular subject field, these are secondary. We feel very strongly that vocational training can best be accomplished outside of the hospitals, in schools which are organized for that specific purpose. It should also be pointed out that in designing the Light Mechanics Procedure there was recognition of the principles of production in industry, whereby an employee performs only certain operations and rarely is called upon to perform all of the operations necessary to fabricate a product. Thus, with notable exceptions, a worker does not make a lamp or construct a piece of furniture or a radio or typewriter. It will be noted that when a patient has completed the Light Mechanics Procedure, he has nothing to send home or to sell.

The Light Mechanics Procedure was developed over a period of approximately two years. From the time that its principles were conceived, an infinite amount of study was necessary in order to select the basic activities which have been included in the Job Units. The procedure is being introduced into our hospitals slowly, and only after the therapists who are to use this technique, have received proper indoctrination. While we believe that experience with it will justify our expectations, the procedure is being subjected to very careful study. Obviously, the Light Mechanics Procedure covers only a segment of industry. Similar procedures remain to be developed in the areas of Medium and Heavy Mechanics. There is also the field of construction and building trades, including woodworking, to mention but a few of the many areas of industry for which standardization similar to the Light Mechanics Procedure may be indicated. For the present, we are encouraging our

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hospitals to utilize activities which are carried on in the various services of the institution, such as the Utility Unit, which is concerned with plant maintenance and includes work in plumbing, electrical maintenance, motor maintenance, structural maintenance; the various administrative offices of the hospital, where a study of clerical work is carried on; the laboratories, including photographic darkroom, where a patient whose vocational objective lies in these fields may be sent for evaluation.

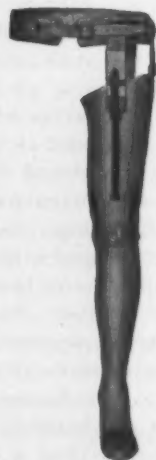
Finally, mention should be made of the activities which are carried on in our Educational Therapy Program. Here, activity situations are set up for patients who are planning to return to school following discharge from the hospital, for study in academic or commercial fields. Here again, while it may be true that the patient derives familiarity with his subject fields, from the physician's standpoint, Educational Therapy and the activities which are prescribed serve as a means for reconditioning, as well as testing physical capacity.

*In summary:* In the formulation of plans for the treatment and rehabilitation of physically impaired patients, it is essential that a rehabilitation goal be established as nearly as it is possible to do so, following admission to the hospital. Only when such a goal has been formulated can the rehabilitation process be outlined in a purposeful manner. In evaluating physical capacity, we are dealing with a

complex of physiologic functions, which are closely interrelated. For this reason, the use of step tests, treadmills and allied procedures provide only a partial club. A more reliable index of physical capacity can be obtained by following the reaction of the patient over a period of time, to realistic activities which he may normally be expected to participate in during a 24-hour day. These are included in the following general categories: self-care, recreation, vocational activity, sleep and rest. Of these, vocational activities are usually the more difficult to explore in the hospital or clinic. Equipment, space and personnel are the major obstacles. In the Light Mechanics Procedure, we have a practical solution to these obstacles.

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# SPECIAL EXERCISE APPARATUS SURVEY\*

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Physical education traditionally has been concerned with "corrective" exercise. Such exercise has been applied to the correction of postural defects and has been used to improve orthopedic disabilities of various sorts. Under the designation of "physical reconditioning" in the armed forces and of "corrective therapy" in Veterans Administration hospitals, the concept of correctives has been broadened to include, not only exercise for improving specific handicaps, but exercises to prevent deconditioning, to improve neuropsychiatric disturbances, and to condition the individual to a satisfactory level of physical fitness. Also, physical therapists are specifically trained in and constantly apply principles of therapeutic exercises.

In certain phases of this process, various pieces of apparatus have been utilized for special exercise purposes. In many instances, the apparatus used has consisted of standard pieces obtained from manufacturing concerns; in other instances, they have been devised and constructed locally.

This survey was undertaken to determine the nature of special exercise apparatus used in various types of institutions conducting remedial (therapeutic) and developmental exercise programs.

## Method

A questionnaire, based upon an analysis of catalogs published by manufacturers of special exercise apparatus, was prepared. The questionnaire was sent to the following individuals and institutions:

1. Corrective physical educators: schools and colleges.
2. Physical therapists: schools for crippled children, community rehabilitation centers, hospitals for crippled and disabled, and Navy hospitals.
3. Physical reconditioning officers: Army hospitals.
4. Corrective therapists: Veterans Administration hospitals.

Of the 567 questionnaires distributed, 317 replies were received, a return of 56 per cent. This survey, however, is based upon replies from 241 institutions, as 66 of the respondents indicated that they were not conducting remedial and developmental exercise programs. The distribution of institutions is as follows:

Veterans Administration Hospitals, 85; colleges, 52; schools, 43; schools for crippled children, 32; rehabilitation centers, 17; and service hospitals, 12.

## General Considerations

The first part of the questionnaire dealt with certain general considerations pertaining to the developmental and remedial exercise program. Information relative to certain of these is given below.

### Assigned Duties

Due to the lack of a common terminology, it is impossible to prepare from the questionnaire replies an accurate account of the specific duties performed in remedial and developmental exercise programs at the various institutions. However, in general, it may be said that:

1. School and college programs placed considerable emphasis on posture correction. Also, especially in the colleges, attention is given to "adapted" activities, i.e., selecting and adapting sports and recreational activities for physically handicapped students.

2. In rehabilitation centers and Navy hospitals, major attention is given to physical therapy treatments, therapeutic exercise (definitive treatment of the disability) and some developmental (reconditioning) work. In schools for crippled children, the same situation exists, except developmental exercise was not indicated on the questionnaires returned.

3. In the Army hospitals, primary concern is with reconditioning, i.e., improving the individual's strength and endurance and preventing deconditioning.

4. The Veterans Administration Corrective Therapy Program reflects great breadth of activity, including reconditioning, therapeutic exercise for all sorts of conditions, assisting with crutch walking and the use of prostheses, neurological therapeutics, resocialization, and the like.

### Defects Treated

A great variety of defects were indicated as being treated in the remedial and developmental exercise programs conducted in the various institutions studied. The distinctive work being done in the remedial and developmental programs at the different types of institutions is also indicated. The schools and colleges are quite comparable, emphasizing posture and foot correction, care of cardiacs and post-operative cases, attention to low physical fitness,

\* The writer was assisted in this survey by Theodore L. Lewis, Edwin F. Simmons, Roger C. Thomas, and Edwin M. Yerdon, graduate students in the "Physical Education and Recreation in Rehabilitation" sequence of studies at Springfield College.



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over- and under-weight conditions, and the like. The rehabilitation centers and the service hospitals treat orthopedic conditions and surgical-medical cases; the rehabilitation centers also include many individuals with cerebral palsy. The Corrective Therapy Program in the Veterans Administration hospitals is distinctive in the large number of patients treated with orthopedic disabilities, amputations, hemiplegia, and paraplegia, neurological conditions, psychiatric disturbances, and the like. Some emphasis by all types of institutions is placed on orthopedic disabilities and by all but Army hospitals on poliomyelitis victims.

### *Testing Instruments Employed*

The amount of objective testing utilized in the remedial and development exercise programs at the various institutions appears to be rather meager, if the use of testing instruments is a criterion. The goniometer has greatest use by all types of institutions but the public schools. Strength-testing procedures also receive considerable attention: the manometer in Veterans Administration hospitals, colleges, and public schools; the back and leg dynamometer, in colleges and schools; and graduated weights and manual procedures in Veterans Administration hospitals. The schools and colleges utilize photography, posture screens, plumb line, and the pedograph to record posture and foot positions.

### *Special Exercise Apparatus*

In the second part of the questionnaire, the following information was obtained from the various institutions participating in the study: (1) the items of special exercise apparatus in their possession; (2) the items not owned but believed helpful; (3) an evaluation of the items included in the study; and (4) suggestions for changes in construction of items listed.

### *Items Owned*

A summary of items owned by the various types of institutions is as follows:

*Largest number:* The items owned by the largest number of all type institutions are: gymnasium mats, stall bars, massage tables, and some form of pulley weights, usually the chest or the floor and chest weights. The three-way mirror is owned extensively by colleges, schools, schools for crippled children, and rehabilitation centers; medicine balls, by V.A. hospitals, colleges, and schools; rowing machines, stationary bicycles, adjustable bar bells, and iron dumbbells, by V.A. and service hospitals; movable walkers, by V.A. hospitals, schools for crippled children, and rehabilitation centers, and service hospitals; balance beams and climbing ropes, by colleges and schools.

*Least number:* The items owned by the fewest number of all types of institutions include: climbing

apparatus, such as ball rope, knotted rope, rope ladder, and climbing pole; pulley weights, with the notable exceptions of chest and floor and chest weights, listed above; over-head ladders of various types and traveling rings; and De Lorme tables. In the schools and colleges, there is a dearth of special exercise items, such as wrist circumductors, shoulder wheels, arm machines, wrestling machines, finger boards; and the rehabilitation centers are limited in the number of different pieces of special exercise apparatus which they have. As shown in the next section, however, they would like to own many other items of this type of equipment.

### *Items Desired*

*Veterans Administration Hospitals:* De Lorme table, arm machine, quarter circle and pulley weight, abdominal mat and pulley weight, wrestling machine, leg pulley weight, intercostal and chest pulley weight, balance beam, neck pulley weight, nautical wheel, triplex pulley weight, massage plinth, and rest pads.

*Colleges:* Foot inversion tread, hand-wrist-forearm table, stationary bicycle, shoulder ladder, wrist circumductor, leg pulley weight, nautical wheel, triplex pulley weight, suspended parallel bars, ankle exerciser, De Lorme table, finger board, and shoulder wheel.

*Schools:* Abdominal mat and pulley weight, suspended parallel bars, stationary bicycle, rowing machine, arm machine, suspended horizontal ladder, nautical wheel, wrist machine, neck pulley weight, foot inversion tread, and rest pads.

*Schools for crippled children:* Wrist machine, ankle exerciser, hand-wrist-forearm table, nautical wheel, floor and chest pulley weight, neck pulley, arm machine, triplex pulley weight, and shoulder wheel.

*Rehabilitation centers:* Leg pulley weight, De Lorme table, hand-wrist-forearm table, triplex pulley weight, balance beam, ankle exerciser, arm machine, striking bag drum, and intercostal and chest pulley weight.

*Service hospitals:* Quarter circle and pulley weight, neck and pulley weight, triplex pulley weight, arm machine, intercostal and chest pulley weight, abdominal and mat pulley weight, suspended parallel bars, rowing pulley weight, balance beam, and traveling rings.

*Summary:* A selection of the items most desired by the institutions as a whole would include: arm machine, triplex pulley weight, neck pulley weight, nautical wheel, De Lorme table, abdominal pulley weight, leg pulley weight, intercostal pulley weight, balance beam, hand-wrist-forearm table, suspended parallel bars, and ankle exerciser.



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## Owned and Desired: Combined

Table I indicates the number of institutions owning and desiring each of the pieces of special exercise apparatus included in the study. On the basis of this analysis, the following summary is presented:

**Largest number:** The items owned and desired by the largest number of all type institutions are stall bars and floor and chest pulley weights. Listed high by all but one of the types of institutions are the following: gymnasium mats, rowing machine, stationary bicycle, ankle exerciser, three-way mirror, and massage table. All but two of the types of institutions included: shoulder wheel, chest pulley weight, and medicine ball. Iron boots, wrist roll, iron dumbbells,

adjustable bar bells, and wrist machine have high listings by Veterans Administration hospitals and schools for crippled children; balance beam, climbing rope or pole, and foot inversion tread, in colleges and schools; and the De Lorme table, finger board, and hand-wrist-forearm table, in rehabilitation centers and service hospitals.

**Least number:** The items owned and desired by the fewest number of all types of institutions (with the exception of schools) were the climbing ropes and poles and the counterbalanced adjustable ladder. The De Lorme table and the movable and stationary walkers were not found or desired in schools and colleges; the rowing pulley and traveling rings, in

TABLE I  
Items of Special Exercise Apparatus  
Owned and Desired (Combined by the  
Various Institutions)

Apparatus Item	V. A. Hospitals (85)	Colleges (52)	Schools (43)	Crippled Children's Schools (32)	Rehab. Centers (17)	Service Hospitals (12)
1. Nautical Wheel.....	53	25	15	15	9	9
2. Wrestling Machine.....	40	18	13	7	5	8
3. Arm Machine.....	60	21	14	11	8	10
4. Wrist Machine.....	70	26	16	17	10	11
5. Rowing Machine.....	79	30	23	15	9	10
6. Striking Bag Drum.....	67	26	17	6	9	10
7. Chest Pulley Weight.....	78	36	25	12	13	8
8. Quarter Circle and Pulley Weight.....	47	18	15	7	4	9
9. Floor and Chest Pulley Weight.....	76	31	23	18	13	10
10. Neck Pulley Weight.....	46	22	14	7	4	9
11. Leg Pulley Weight.....	53	20	12	10	13	8
12. Rowing Pulley Weight.....	31	16	15	8	6	7
13. Intercostal and Chest Pulley Weight.....	56	26	15	7	10	9
14. Triplex Pulley Weight.....	51	21	14	11	9	9
15. Abdominal Mat and Pulley Weight.....	48	17	18	8	7	8
16. Suspended Parallel Bars.....	36	23	19	5	6	9
17. Balance Beam.....	44	41	23	9	10	8
18. Suspended Horizontal Ladder.....	37	28	25	6	6	9
19. Massage Plinth.....	51	33	17	8	9	6
20. Massage Table.....	68	37	26	23	16	11
21. Iron Dumbbells.....	73	30	16	9	12	11
22. Adjustable Bar Bells.....	71	23	15	9	12	11
23. Traveling.....	27	22	18	7	3	9
24. Counterbalanced Adjustable Ladder.....	20	12	12	3	4	5
25. Stall Bars and Bench.....	78	46	35	24	16	11
26. Boxing Training Bag.....	55	21	10	4	5	9
27. Climbing Pole.....	17	17	11	3	4	4
28. Climbing Rope.....	28	31	30	4	2	9
29. Ball Rope.....	19	13	12	3	4	6
30. Knotted Rope.....	17	13	12	5	4	7
31. Rope Ladder.....	21	14	9	3	4	6
32. Ankle Exerciser.....	72	22	13	15	13	11
33. Bicycle, Stationary.....	78	28	23	22	15	11
34. Chinning Bar.....	66	6	10	11	7	11
35. De Lorme Table.....	63	17	9	10	14	10
36. Finger Board.....	65	21	8	13	13	10
37. Foot Inversion Thread.....	66	33	23	13	11	10
38. Hand, Wrist Forearm Table.....	55	21	7	13	13	10
39. Iron Boots.....	76	25	11	13	12	11
40. Mats, Gymnasium.....	80	48	36	25	10	11
41. Medicine Ball.....	72	33	29	9	9	11
42. Mirror, Three-way.....	72	38	33	21	15	10
43. Rest Pads.....	52	27	23	12	11	7
44. Shoulder Ladder.....	70	20	9	10	13	8
45. Shoulder Wheel.....	82	22	11	21	13	11
46. Walker, Movable.....	74	18	7	19	12	6
47. Walker, Stationary.....	50	17	8	10	11	8
48. Wall Parallel Bars.....	52	21	13	14	12	8
49. Wrist Circumductor.....	68	18	9	7	7	10
50. Wrist Roll.....	74	26	9	8	9	11

# SPECIAL EXERCISE APPARATUS SURVEY

V.A. hospitals; the wrestling machine, wrist circumducter, chinning bar, and quarter circle, rowing, and abdominal mat pulley weights, in colleges; the hand-wrist-forearm table, finger board, shoulder ladder, wrist circumducter, and wrist roll, in schools; the boxing training bag and suspended parallel bars, in schools for crippled children, the neck pulley weights and traveling rings, in rehabilitation centers; and rowing pulley weight, movable walker, and massage plinth, in service hospitals.

## Different Types of V.A. Hospitals

A comparison of special exercise apparatus owned and desired by the three types of V.A. hospitals (general medical and surgical, neuropsychiatric, and tuberculosis) follows.

1. *Tuberculosis hospitals:* Very little special exercise apparatus is owned or desired by the seven tuberculosis hospitals answering the questionnaire.

2. *General medical and surgical hospitals:* The reverse is true in the 54 general medical and surgical and in the 24 neuropsychiatric hospitals that replied. All of these hospitals listed rowing machines, stall bars, stationary bicycles, iron boots, gymnasium mats, and shoulder wheels; all but one included chest pulley weights and floor and chest pulley weights. Other items with high listings were wrist machines, massage tables, iron dumbbells, adjustable bar bells, ankle exercisers, medicine balls, movable walkers, and wrist rolls.

3. *Neuropsychiatric hospitals:* In the neuropsychi-

TABLE II  
Evaluation of Special Exercise Apparatus  
By the Various Institutions

Apparatus Item	V. A. Hospitals (85)	Colleges (52)	Schools (43)	Crippled Children's Schools (32)	Rehab. Centers (17)	Service Hospitals (12)
1. Nautical Wheel	80	29	13	15	14	9
2. Wrestling Machine	45	17	11	4	1	2
3. Arm Machine	84	27	13	13	4	4
4. Wrist Machine	111	35	14	20	9	16
5. Rowing Machine	172	53	30	23	9	22
6. Striking Bag Drum	140	36	17	11	1	13
7. Chest Pulley Weight	190	55	41	23	20	15
8. Quarter Circle and Pulley Weight	62	19	19	7	0	0
9. Floor and chest Pulley Weight	183	52	34	24	19	22
10. Neck Pulley Weight	67	28	18	8	4	0
11. Leg Pulley Weight	76	28	14	13	10	8
12. Rowing Pulley Weight	39	21	15	16	7	4
13. Intercostal and Chest Pulley Weight	98	40	16	10	7	4
14. Triplex Pulley Weight	103	30	16	18	2	2
15. Abdominal Mat and Pulley Weight	67	28	19	10	2	0
16. Suspended Parallel Bars	55	27	30	4	2	2
17. Balance Beam	59	55	39	15	4	2
18. Suspended Horizontal Ladder	55	42	47	8	0	4
19. Massage Plinth	97	49	30	21	15	12
20. Massage Table	189	69	40	63	38	24
21. Iron Dumbbells	168	52	21	12	19	25
22. Adjustable Bar Bells	171	44	18	13	22	18
23. Traveling Rings	27	30	19	12	2	2
24. Counterbalanced Adjustable Ladder	22	18	12	0	2	0
25. Stall Bar and Bench	175	102	72	51	21	18
26. Box Training Bag	101	25	13	2	2	7
27. Climbing Pole	19	41	14	2	0	0
28. Climbing Rope	38	19	36	3	2	6
29. Ball Rope	23	15	17	2	0	0
30. Knotted Rope	31	18	19	3	0	0
31. Rope Ladder	23	14	8	3	0	0
32. Ankle Exerciser	136	31	19	23	14	15
33. Bicycle, Stationary	204	52	27	42	24	26
34. Chinning Bar	132	61	48	18	3	18
35. De Lorme Table	145	24	7	19	15	18
36. Finger Board	126	27	12	28	17	12
37. Foot Inversion Thread	103	49	31	30	18	13
38. Hand, Wrist, Forearm Table	106	34	14	24	7	11
39. Iron Boots	189	44	17	23	24	23
40. Mats, Gymnasium	201	121	82	63	34	32
41. Medicine Ball	136	58	55	16	9	14
42. Mirror, Three-Way	196	106	84	47	31	21
43. Rest Pads	99	54	43	25	17	8
44. Shoulder Ladder	140	32	16	18	14	12
45. Shoulder Wheel	190	34	14	27	21	18
46. Walker, Movable	187	28	8	42	28	19
47. Walker, Stationary	130	27	8	27	22	2
48. Wall Parallel Bars	116	35	19	29	16	5
49. Wrist Circumducter	114	25	11	10	4	16
50. Wrist Roll	126	38	14	9	9	16

## SPECIAL EXERCISE APPARATUS SURVEY

atric hospitals, all but one installation either owned or desired rowing machines, striking bag drums, quarter circle pulley weights, stationary bicycles, gymnasium mats, shoulder wheels, movable walkers, and wrist rolls. Other items with high listings were floor and chest pulley weights, iron dumbbells, adjustable bar bells, stall bars, boxing training bags, chinning bars, iron boots, medicine balls, rest pads, shoulder ladders, stationary walkers, and wrist circumductors.

### *Evaluation of Special Exercise Apparatus*

In conducting this survey, an evaluation of special exercise apparatus was made. Users of such apparatus in the various types of institutions included in the study were asked to judge the value of each of the fifty items listed on the questionnaire. The basis for evaluating the items and the scale used to indicate the value of each item were as follows:

Evaluation	Scale Score
Item is indispensable.....	3
Item is very useful.....	2
Item is helpful.....	1
Item is unnecessary.....	0
(Seldom if ever needed)	

### *Overall Evaluation*

The results of this evaluation appear in Table II. In general, it will be seen that the Veterans Administration and service hospitals have a much higher regard for the use of special exercise apparatus in conducting their Corrective Therapy and Physical Reconditioning Programs than have the other type institutions in conducting comparable programs. For example, the number of items receiving an average rating of 1.5 for the various types of institutions were as follows: Veterans Administration hospitals, 20 items; service hospitals, 9 items; rehabilitation centers, 3 items; colleges, 1 item; and schools and schools for crippled children, 0 items. These figures are even more significant when it is realized that the tuberculosis hospitals, where little special exercise apparatus is used, reduces the score for the V.A. group and that a similar situation exists in the service hospital group, where Navy hospitals do not utilize such equipment extensively.

**Highest ratings:** The following four items of special exercise apparatus were given high ratings by all types of institutions: gymnasium mats, three-way mirrors, massage tables, and stall bars. The stationary bicycle received high rating by all types of institutions but the public schools; the shoulder wheel and movable walker by all but colleges and public schools; and chest pulley weights by all but schools for crippled children and service hospitals.

The chinning bar, medicine balls, balance beam, and rest pads were rated high by colleges and schools;

iron boots, floor and chest pulley weights, and rowing machines, by V.A. and service hospitals; iron dumbbells, by colleges and service hospitals; bar bells, by rehabilitation centers and service hospitals; stationary walkers, by schools for crippled children and rehabilitation centers; suspended horizontal ladder, by schools; and foot inversion tread, finger board, and wall parallels, by schools for crippled children.

**Lowest ratings:** In general, the climbing poles and ropes, certain of the pulley weights, the boxer's training bag, and suspended parallel bars and horizontal ladder received low ratings by the various institutions. The following three items were rated low by all types of institutions: counter-balanced adjustable ladder, rope ladder, and wrestling machine. The pulley weights receiving low ratings were the rowing and the quarter circle. Low ratings of other items of apparatus were limited to specific type of institution.

### *Veterans Administration Hospitals*

A special analysis was made of the ratings given special exercise apparatus by the different types of Veterans Administration hospitals, in order to determine differences that may exist between general medical and surgical, neuropsychiatric, and tuberculosis hospitals.

Only three items received high ratings by tuberculosis hospitals, as follows: massage table, three-way mirror, and shoulder wheel. Both the general medical and surgical and the neuropsychiatric hospitals gave high ratings to the stationary bicycle, iron boots, gymnasium mats, three-way mirror, chest and floor and chest pulley weights, shoulder wheel, and movable walker. The neuropsychiatric hospital favored items which would provide release of tension through violent action, such as striking bag drums, boxing training bags, rowing machines, and medicine balls. The general medical and surgical hospitals also gave high ratings to massage tables, stall bars, iron dumbbells, and adjustable bar bells.

### *Summary*

Throughout the survey, it was quite obvious that special exercise apparatus is used much more extensively and is considered of greater value in developmental and remedial programs in Veterans Administration and Armed Service hospitals than is true for other-type institutions. To understand completely the reasons for this situation, it would be necessary to study the various programs in considerable detail. Speculatively, however, these hospitals are distinctive in the following respects: (1) Disabilities of all types are encountered in some numbers; (2) the programs constitute a technical specialty within their

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# TECHNIQUES IN MOTIVATING ACUTE NEUROPSYCHIATRIC PATIENTS VIA CORRECTIVE THERAPY

By MICHAEL YAROSH, B.S.

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Wilkes Barre, Pennsylvania  
1951

Acute neuropsychiatric patients confined to locked wards render a challenge to all hospital personnel. The ever present question mark (?) — "Can you make me feel like I once was?" — is the challenge. How can we aid, what techniques, devices or vehicles of approach and motivation can we employ in working with these acute, locked ward patients?

This article will, therefore, deal entirely with the Corrective Therapist who attempts to motivate a mentally ill patient into a physical activity.

Therefore it is necessary that after careful evaluation is made by the psychiatrist and his staff, the therapeutic objectives are assigned to Corrective Therapy, which represent an individualized activity approach to the patient. The acutely ill psychotic patient may be hyperactive, negativistic, catatonic, stuporous, etc. Successful or noneffective relationships can be the result of an approach which is maintained for several days or for many months. From experience in association with the mentally ill, it becomes necessary to consider the first contact with a patient as a very important one, perhaps the most crucial one.

Many can recall the motion picture "Snake Pit" in which the patient was subjected to meeting professional people who in turn employed diverse approaches with as many different results. The motion picture also portrayed patients influencing each other toward friendliness or hate with a keen degree of sensitivity.

At times the only remaining approach is through a patient's friend who is confined in the same group. Suggestions of motivation can be made by the Corrective Therapist to the friend of the inaccessible individual. The approach is indirect; however, it does provide an opening to contact the patient. Our object is to find the best methods of establishing a rapport with a patient in order to attain enduring therapeutic results.

Corrective Therapists have found and realize that persons in a state of acute mental illness are exceedingly difficult to approach. Therefore, it becomes

*"Sponsored by the V.A. and published with the approval of the Chief Medical Director. The statements and conclusions published by the author are the results of his own study and do not necessarily reflect the opinion or policy of the Veterans Administration."*

necessary to approach the patient through a knowledge of numerous interests which the patient has buried in his background. His interest may manifest itself in the form of a sport, occupation, hobby, or educational pursuit. The varying range may extend from a low organized sport activity to one of complex camera design and repair. It is necessary for the therapist to know the patient's social history as well as his present and past medical history. The Corrective Therapist evaluates the information supplied by Social Service and the psychiatrist's report, including findings of the tests by psychologists, to learn the level of the patient's mental capacity, and if possible, some of the factors which upset his emotional equilibrium. The therapist, in consultation with the psychiatrist, decides whether his approach shall be encouragement into a physical activity or conversing with the patient during the course of several periods, for example, on his basketball participation in grade school, college, or industrial teams. This conversation may even be concerned with the proper method to bait hooks for bass fishing.

When a patient tells a therapist, "You remind me of my damned old man," or "I know a fellow who looks like you and I don't like him," and if the patient repeatedly continues to make such statements, it is good judgment to assign the patient to another therapist to avoid constant hostility. It is very important that a Corrective Therapist accomplish interpersonal relationship without a clash of personalities.

The therapist attempts to elicit a response to his personality from the patient strictly on an interested and friendly basis. Once this rapport is established with sympathetic understanding, favorable therapist-patient relationship is less difficult to attain and is more likely to last.

There still remains the need of another distinctive approach to be employed in the motivation of the acute neuropsychiatric patient, when the therapist is not supplied with any information concerning the patient. Moreover, it is considered good therapy for the therapist to establish an effective inter-personal relationship without hindering his attempts, consciously or unconsciously, with a knowledge of the patient's past life. Out of necessity the therapist-patient relationship must be mutual, since they are not familiar with each other. The attitudes and motivation developed will have been one with a clean,



## TECHNIQUES IN MOTIVATING ACUTE NEUROPSYCHIATRIC PATIENTS VIA CORRECTIVE THERAPY

uninfluenced beginning. The Corrective Therapist has the unique advantage of acquiring information from the acutely disturbed patient because he has the time to wait until the patient is ready to voice his expressions which follows a sound therapist-patient relationship. When a patient is in a relaxed attitude and is in the proper frame of mind to talk, he is not subjected to question-and-answer pressure such as he would customarily encounter in the closed-door atmosphere of the doctor's office. The Corrective Therapist does not ply him with embarrassing questions pertaining to mental, physical, and social reactions which may be associated with feelings of guilt. On many occasions the Corrective Therapist must find that he himself becomes the person with the capacity to listen without registering any emotion, expression, or giving opinion. The place may be under the cool shade of a tree, in the swimming pool on a hot day, out bicycling, or in the ward playing a game of checkers.

The following illustrates the benefits of intensive teamwork and the importance not only of electric shock therapy, but of relationship therapy which is so evident in the treatment of this patient.

Further study and evaluation in the future will lead to a determination of the best approach in which the therapist has a knowledge of the patient's mental, physical, social, educational past, or an approach wherein the therapist-patient interpersonal relationship is formed with the unobscured meeting of two people in common corrective therapy situations.

Let us observe the schizophrenic paranoid on his first visit with the group to the corrective therapy clinic. Usually a paranoid in an acute state wanders about the clinic for several days without speaking to anyone; if he is a smoker, he may smoke incessantly. His only activity is walking about the clinic and observing activities of shuffleboard, ping-pong, or basketball in a disinterested manner. However, the Corrective Therapist approaches the patient several times during a period to engage him in any activity where even slight interest is manifested.

Let us inspect the realm of play more closely and observe why it serves as one of the best vehicles in the treatment of the mental patient. One of the first objects aside from the rattle that an infant reveals some proficiency in handling, holding, rolling and tossing, is a colored ball. Any time that a ball is within reach, the infant is content to fathom its mystery of motion by the hour with careful and minute scrutiny. As a child grows older, this familiar object becomes an integral part of his play pattern. *The ball becomes a symbol for play activity.* It may vary in size to conform with the activity; nevertheless,

from infancy through adolescence, adulthood, and old age, the ball always has encouraged response in that it serves:

1. To encourage release of natural physical energy and induces natural fatigue.
2. To promote satisfying physical coordination.
3. To create responsibility in defense positions.
4. To develop aggressiveness to score.
5. To teach the individual that success depends on contribution to and from the group.
6. To elicit a response in a mentally ill patient who may be devoid of all activity, including the eating of food.
7. To provide a vehicle of approach for the Corrective Therapist.

Even though a patient becomes isolated in his own dim vegetated state, he is likely to respond to an object tossed directly at him. A soccer ball to begin with or an eight-pound medicine ball ideally fulfills this need. The concept behind tossing a ball is, that a ball tossed directly at a patient will motivate his instinctive impulses either to catch it or to get out of its way. The ball also affords a tangible object with reality. In his hands he can feel its form and size, judge its weight, color and texture. Above all else, it seems to be a familiar object. After passing the ball a number of times to the patient from a distance of five feet, the therapist moves backward, a pace at a time, until the patient is tossing the ball a distance of fifteen feet or more. If the patient is only lobbing the ball or floating it through the air, he is encouraged to throw the ball with force to stimulate dormant aggressiveness.

After four or five days of this activity, two balls are thrown simultaneously in an exchange. This activity results in faster physical reactions, more accurate hand and eye coordination, and keener concentration. With an increased tempo of activity, he does not have the time to listen and reply to auditory hallucinations which in time may tend to subside. In this manner, the patient has perhaps developed his first interpersonal contact with one individual, his friend, the Corrective Therapist. The next important step is to encourage a similar activity with two other patients until the paranoid individual is participating with the group. His world changes very slowly from one of complete inactivity to one of movement in a pattern, in rhythm with other people. Patients in turn stimulate each other in physical action, to yells of encouragement, to friendliness, and even to the tonic of laughter. At this stage the patient will encounter his first competition in the group. The therapist, observing the patient's attitude, renders

consolation and guidance accordingly. He praises the patient for good plays on the field, as well as for good decisions. The therapist can also lead the patient into making decisions. "That was a close toss. Whose point is it?" or "What would you have done if you were at bat?" It is also important to note that a man is more inclined toward conversation following a stiff physical workout. The therapist at this time should be the eyes and ears of the psychiatrist. He should encourage the patient to release his thoughts from his mind.

The case of J. N. presents another type of problem as well as another picture, and illustrates the intensive teamwork and the importance not only of electric shock therapy but the relationship-therapy as well. J. N., a forty-six year old white male, was diagnosed as a schizophrenic paranoid. He was a bed patient for the past two years, tube-fed and non-ambulatory, with severe dystrophy of the entire body. In his mind he had a broken back, injured left wrist, and right leg, none of which was clinically true. He heard voices and addressed them with emotion and anger.

The attendant brought the patient from the acute locked ward into the clinic in a wheelchair. The patient was allowed to observe exercises and drills given to orthopedic ward patients on a 24 ft. by 24 ft. wrestling mat. In the first three periods the patient was allowed to familiarize himself with the Corrective Therapist, the clinic, and with patients who were not mentally ill but handicapped in body, with arm and leg amputations, plaster casts, and so forth. This paranoid individual made inquiries concerning their injuries and feelings. The Corrective Therapist explained their injuries in a simple manner, and related how they had been incurred. This illustrates that this mentally ill patient could be drawn into a conversation through his concern for and interest in other patients. This verbal interest did not include the attendants, nurses, doctors, or the Corrective Therapist.

When the therapist aided the paranoid patient to his feet to develop balance and weight tolerance on atrophied quadriceps muscles, his audience—the orthopedic patients—rendered approval and encouragement. Once more the patient was taught the art of walking, as he had been in childhood, with kind attention and human understanding. At this point the Corrective Therapist must bring his most notable piece of equipment into play—his personality and persistent belief that he can aid in building the future of the patient. He must maintain this start in physical exertion and display his initiative in prolonging it as the months slip by, until the patient is fully ambulatory. Upon ambulation, this acute

schizophrenic paranoid exercised with ten-pound dumbbells, a 25-pound barbell, pitched quoits, kept score, rode a stationary bicycle, and challenged other patients to games of ping-pong. His references to his inabilities gradually vanished. He began swimming with the aid of an inner-tube, and through the aid of the therapist he remained in the water for periods of forty minutes and finally one hour. Every opportunity was employed advantageously to stimulate the patient into physical activity and group participation. Thus he was weaned away from being a living but inactive organism, and was once more becoming a moving, articulate human being. Progress notes were maintained and referred to the psychiatrist by the Corrective Therapist, noting the patient's attitude, remarks, and behavior both in as well as out of group situations. In this way the patient paved a way into the psychiatrist's confidence, and consequently a trial on the open ward was much nearer.

In summary, corrective therapy provides an individualized approach to the acute psychotic patient who cannot adjust readily to group relationships. As Dr. John Eisele Davis reminds us, "these patients may be appealed to most effectively upon the non-verbal level in which they deal with concrete things, rather than conceptual ideas. Informal play activities may break through the autistic barriers of these difficult types. It should be remembered, however, that activity per se is not the therapeutic objective. These activities are simply vehicles for the purpose of creating desirable interpersonal relationships. Once the patient is attracted into activity, the next step is to create a strong person-to-person rapport in which the therapist attempts to get close to the patient, to become genuinely friendly. It is in this area of warm friendliness that the therapist is enabled to develop motivational techniques. Once the initial phase, i.e. the beginning of the patient into activity, is attained, the second step is concerned with the continued participation of the patient in constructive therapy. Methods of sustaining interest and pointing to increasingly progressive levels of activity become important. It is here that the ingenuity and resourcefulness of the therapist come to the fore. New elements must be injected so that the patient can see definite steps toward goals which he deems worthwhile to him. The therapist gives continued study to the patient, his interest, his likes and dislikes; the social history, his family background, his childhood activities, his skills, his educational and social environment. The science of therapy becomes an art, the art of understanding and influencing people."

It behooves all persons who have contact with the acutely ill neuropsychiatric patients to synchronize

their efforts and aims toward effecting a change in the clinical picture of the patient from abnormal to normal.

This article will miss its purpose completely if any Corrective Therapist believes that only what he is doing is helping to create a change. The doctors who do electric shock, insulin shock, and other related psycho-therapeutics, the nurses and the attendant staff with their continuous care and contact with the patient—all attempt to make the regressed individual approachable. Likewise, Corrective Therapists must depend on the aid of the entire neuropsychiatric staff in activating patients in even such simple motivative activities as tossing and catching a ball. It is only by the combined efforts of all accentuated milieu therapies that each of us has lit a lamp along the darkened pathway in aiding a patient to ascend from the pit of darkness into the light of day.

When the time arrives for a patient to return to his own family, his home and his occupation and when he stops by to say, "Thanks for all the help you have given me, I must have been mighty sick," we can all feel that a step forward has been made from medieval neuropsychiatric history into the progressive light of twentieth-century psychosomatic medicine.

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## SPECIAL EXERCISE SURVEY—

(Continued from Page 13)

divisions of physical medicine; (3) specially trained and experienced physical educators conduct these programs under close medical supervision; (4) personnel, equipment, and facilities, in the main, have been adequate for the job at hand; and (5) the personnel directly involved have been especially alert to develop effective exercises and physical activities for the various types of disabilities encountered.

Because of these conditions, special attention in physical education might well be directed toward these Veterans Administration and Armed Services developmental and remedial programs. Much of the materials and many of the methods being developed may logically be applied to comparable programs in colleges, schools, rehabilitation centers, and schools for crippled children.

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# THE APTITUDE SHOP IN NEUROPSYCHIATRIC HOSPITALS\*

By OREON K. TIMM, M.D.

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For some time the possibilities of an aptitude shop as an integral part of the total therapeutic effort in a large neuro-psychiatric hospital have been under study at the Danville Veterans Administration Hospital. The original unit was suggested and set up by the Chief of Manual Arts Therapy Section of Medical Rehabilitation and was designed to give the patient assigned to Manual Arts Therapy an opportunity to try his hand at various types of machine and bench work. He was observed and coached by an instructor possessing a wide knowledge of various shop activities. His potentialities were assessed by the instructor, and on the basis of this evaluation he was assigned to the appropriate activity in Manual Arts Therapy or referred back to the assigning physician as unsuited for that particular section in Rehabilitation Therapy. This was a valuable service and in itself justified the unit.

In an effort to increase therapeutic efficiency and to bring about a higher degree of exactness in fitting therapy to the patient, an administrative change was introduced into the entire rehabilitation program.

Many of the patients assigned to Medical Rehabilitation present clear-cut indications for particular therapies, but in others the indications are not so apparent. It was to meet the needs of this latter group that the activities of the aptitude shop were expanded. One of the more advanced Psychology Internes was assigned to this unit to study each patient sent there for observation and evaluation.

On his initial visit to the shop the patient is interviewed privately by the psychologist who has previously checked over the clinical file and abstracted those facts which may provide leads in the placement studies. As the Wechsler-Bellevue test is done routinely on the admission service the intelligence level of the patient is known. Other standard psychological tests such as the Thematic Apperception Test, the Minnesota Multi-phasic, and the Rorschach may or may not have been completed during the diagnostic evaluation. Any not previously accomplished which appear

to be of value in light of information obtained during the interview are administered and interpreted from the standpoint of therapeutic indicators or as indices to complexes and conflicts pertinent to the treatment problem.

With the introduction of the psychological study the scope of the aptitude shop was greatly enhanced. Whereas before it functioned only to determine if a man could adapt to Manual Arts Therapy and if so to what particular phase, the new approach provided for evaluation of likelihood of benefit from any section of Rehabilitation Therapy. This is not to say that the old activities of the unit are not of equal value, for they do continue to contribute vitally to the total function. The psychological study and the practical trials in the shop operate as a unit. To illustrate how the unit works, the hypothetical case of a severe psychoneurotic of high intelligence may be considered. It may be assumed that he is a young man who left high school before securing his diploma and since his hospitalization he has expressed the desire to take some work in Educational Therapy with the idea of securing some additional high school credit. Cases of this type are fairly common and super-

ficially it would appear that the logical procedure would lie in an Educational Therapy assignment. However, the psychological study may well bring out emotional constriction or depression arising out of guilt feelings with resulting attention defect of such magnitude as to doom any formal educational attempt to certain failure, with additional frustration resulting to complicate the clinical picture. On the other hand such individuals may be able to sublimate their feelings of aggression and hostility through the use of cutting tools. A trial at the various benches in the shop will show whether the patient can best adapt (and hence avoid frustration) to the gross operations of carpentry or the finer ones of wood carving or leather tooling. The proper assignment of such aids the psychotherapist by reducing tension. In another hypothetical situation the psychological study may point to a Manual Arts assignment as the proper one. However, at the bench the patient appears clumsy, perhaps because of residuals of a conversion symptom. A course of treatment in Corrective Therapy may be

\* Reviewed in the Veterans Administration and published with the approval of the Chief Medical Director. The statements and conclusions published by the author are the result of his own study and do not necessarily reflect the opinion or policy of the Veterans Administration.



## THE APTITUDE SHOP IN NEUROPSYCHIATRIC HOSPITALS

what is really needed. A final example based on an actual case may be cited. A successful electrical bench worker was admitted and studied. Psychotherapy was instituted and Manual Arts Therapy prescribed as adjunct. Obviously he showed aptitude for electrical work. However the psychological studies showed that much of his tension centered about a situation at his place of employment. Accordingly he was assigned to the greenhouse. The treatment plan was apparently adequate as it was possible to discharge him after a brief period of hospitalization.

After the studies in the aptitude shop are completed the psychologist and the instructor present their data to one of the physicians in the Rehabilitation Department who then makes the prescription for therapy on the basis of all the information about the patient at his disposal. This procedure has been productive of generally good results, but the author was of the opinion that the practical potentialities of the aptitude shop should be further developed.

Aptitude testing in a neuropsychiatric hospital is inseparably bound up with the Therapy program. This is true because in the mental hospital the goal is usually not to determine aptitudes with the idea of teaching a vocation. Rather it is always primarily to find out what portion of the patient's personality is left to work with and how it can be best utilized as a lever to bring the total personality back to the realm of reality. If a vocation or the foundation for a vocation is achieved incidentally by the patient during his treatment, that is a distinct gain; but with very occasional exceptions, it is a secondary gain.

Any further extension of aptitude shop usefulness in the total therapy program depends on an understanding of the goals of the various modalities of treatment and how Medical Rehabilitation aids in reaching the individual goals. Before it is possible to enlarge further on the possibilities of aptitude shop testing, we must digress long enough to analyze the total treatment program and find the indications of rehabilitation therapy from the viewpoint of mental dynamics.

The overall therapy program in the mental hospital presents two phases. First, there is a direct attack on symptoms and the illness per se; and second, there is the rehabilitation of the personality. These phases might better be characterized as zones, as there is usually considerable temporal over-lapping. This is to say, treatment often proceeds simultaneously in the two zones.

In the First Zone there are five approaches to the direct attack on symptoms or the disease process:

1. *Psychotherapy*—This may take the form of "uncovering" or "insight-producing" on the one

hand or on the other hand it may operate as direct suggestion.

2. *Shock therapy*—in any of its forms.
3. *Drug and Fever-Therapy*—either of which may be curative or palliative.
4. *Push therapy*—designed to break up phantasy and thrust reality upon the patient.
5. *Tension relieving therapy*—which may be directed toward either endogenous or situational sources.

Activities in the Second Zone oriented toward the rehabilitation of the basic personality may be grouped in four categories.

1. Education in orderly living
2. Resocialization—including conquest of fear of interpersonal relationships
3. Dilatation of ego through group identification
4. Development of resources for gaining satisfaction. This may occur in occupational, education, or recreational spheres.

Consideration of the nine points of departure listed above establishes the first three, psychotherapy, shock therapy, and drug and fever therapy as belonging exclusively to the medical domain, whereas the remaining six fall in the province of rehabilitation. At this point we must clarify our thinking and distinguish clearly between the *fundamental* and *incidental* goals of rehabilitation therapy in the NP Hospital. What we are trying to achieve is personality restoration. That our patient learns a trade or masters a course in the process is of little consequence. To put it another way: Consider a patient in Manual Arts Therapy assigned to an ornamental concrete project. *Whether he ever learns to build a bird bath or to mix cement is of minor importance; that he does learn to function as a member of a group and take pride in their achievement, that he realizes once more the satisfaction of productive effort and that he finds out for himself that reality is not always unfriendly and frustrating—these are the major goals.*

It is beyond the scope of this paper to investigate the problem of how the rehabilitation armamentarium can best be applied to achieve those fundamental goals. Suffice it to say that it can be made to accomplish the task, even in many instances where the therapist, lacking full understanding of his mission, has oriented himself to a secondary or incidental goal; but only if the prescription is appropriate. Our immediate concern lies in the investigation of ways and means to guide our patients into the proper channels of therapy so that their treatment will be adapted to their exact needs. It seems clear enough that to accomplish this there must be first, a knowledge of what each therapy project has to offer, and

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## EDITORIALS

### THE PRESIDENT SPEAKS

In reviewing a year of activity, it is difficult to present a fair evaluation of the various functions of the organization. There is a tendency to emphasize the events that are positive in nature and minimize those of a negative quality. A detailed report will be given at our national convention on both the positive and negative aspects. It will be remembered that this year was predicted to be a critical one for the Association. There is no question that major problems have arisen and will continue to confront us in the days ahead. The methods employed to attack these problems have been in accordance with the best advice available from the Advisory Board, the Executive Committee and the Professional Standards Committee. Our goals must be defined clearly to assure success in the future.

Our Association has shown progress despite the many problems encountered. Interest has increased through the formation of new chapters. Local position has been strengthened by conducting interesting, purposeful, and educational programs in the respective areas. Two new chapters and one new section have been organized since last year's convention in Memphis. Further developments in this direction are noticeable in other areas.

In reviewing important meetings held during the year, the Association authorized representation for the following sessions: The Congress of Physical Medicine in Boston, Mass., the Congress of Physical Medicine Subcommittee on Education in Rochester, Minnesota, the Adjunctive Therapy Conference at Menninger Clinic in Topeka, Kansas, and the Committee Meeting in Washington, D. C. for discussion of problems in the field. Results of these sessions will be discussed at length during the business meetings of the Representative Assembly at the Los Angeles Convention. All members are eligible to attend.

In bringing this year of activity to a close, I wish to acknowledge the support given by the Advisory Board when major problems were presented. The Executive Board and the Professional Standards Committee are to be commended for the assistance given in the form of guidance and counseling during critical periods. To those associated with the Journal, I would like to pay special tribute for exceptional accomplishments under extreme conditions. The general committees are not to be overlooked in their efforts which have played a major role in the success of the organization. Finally, I wish to comment on the unusual loyalty and service shown by the lay and professional people outside the regular membership.

To all members and non-members alike who have

been of helpful service during my term of office, I wish to express my sincere appreciation.

### OUR RESPONSIBILITY TO OUR ASSOCIATION

It is only natural that one raises the question as to personal benefit when he is besieged by a veritable barrage of invitations and requests and even admonitions to join another organization. The same question rears up when one begins to analyze reasons for continuing to support an organization. This is even more so when the organization is young and undergoing the growing pains of emerging into manhood. We are well aware of the obstructions to progress of any one group which must break through the rapids of conventionality.

On the other hand, there is a very great and substantial satisfaction in exploring new areas and assisting in the development of ideas, some old and some new, and in aiding the medical profession to give respectability and status to some of the basic concepts of therapy which must be tried out in a medically supervised atmosphere to prove their worth or worthlessness. The Association for Physical and Mental Rehabilitation is at present passing through just such an interesting and challenging experience.

It is the responsibility of any professional association to answer these questions. However, one cannot afford to stop at any point of progress except to look around and survey the opportunities. Our Association is simply the personality of its members; it is you and I, organized into a group and expressing our individual aims and needs in group fashion. The strength of our organization is simply the intelligent energy and sincere spirit which you and I are willing to inject into it. Therefore, we do have a very serious responsibility to our fellow therapists, our profession and to the overall field of medicine. Such responsibility is equalled only by the opportunity afforded in working with the doctor and companion therapist and gaining the advantage of their wisdom and guidance.

To get down to cases, the officers of our association have been and are making sincere efforts to progress the affairs of the association in the right direction. Our journal has become a fine example of professional literature; our membership has shown considerable increase in numbers and in enlisting the interest and active support of leaders in related fields. Our President, George Devins, Burr Zachary, Convention Chairman, and his many active committees, are organizing a high calibre program for the Fifth Annual Scientific and Clinical Meeting.

The Association is our voice. Let us realize that our future as a therapeutic group is closely allied with The Association for Physical and Mental Re-

habilitation, that we have a very definite responsibility to support and strengthen it and that we cannot "let the other fellow do it." Each member should enlist one or more additional members, we should make every effort to attend the Annual Meeting in Los Angeles, we should talk up our association, orient individuals and groups, and continue the very fine work being done in the field in organizing local chapters. It is gratifying to know that many of these things are being done and very excellent progress is being made. As in all organizations, however, there is the ever present tendency for the few to do the work of the many. We cannot afford to make this mistake. We have a democratic organization in the sense that everyone has a voice and we encourage the expression of the individual viewpoint. Let us be democratic in the sense that we are all taking part in the work, responsibilities and rewards of our organization. We need your help, you need ours, so let's get together in a continuous and united effort to raise still higher the status of Corrective Therapy.

JOHN EISELE DAVIS, Sc.D.

## CORRECTIVE PHYSICAL EDUCATION

Throughout the early history of Physical Education, we find that the objective was physical fitness. Fitness for military service was emphasized by the Greeks and Romans. Sweden, Germany, and Denmark established and developed "systems" of body building exercises that were devised for the conditioning of men for military service, and to improve the health and happiness of other individuals, in their societies.

Today, centuries later, we face the same problem of physically fit manpower for the defense of our nation, and to increase man's happiness in the unsettled contemporary life we lead.

Since the close of World War II much has been heard about "Corrective Therapy." This is but a new term denoting corrective or developmental exercise, one phase of Physical Education that has been continuously used in developing gymnasts, athletes, acrobats, dancers, swimmers and other individuals seeking health and happiness.

The average individual with undeveloped muscles, with many evidences of faulty body mechanics, with the deformities resulting from accident or disease, needs the benefits resulting from adapted physical activity, under medical guidance, to restore the fitness and happiness that enables this large group of citizens to make their contribution to our survival off the battlefield.

Physical Education has from its earliest beginnings been advocating, planning and operating programs of activities that fit the needs of the weakling and

the athlete. Widespread recognition of the health maintenance values of exercise has resulted from the intensive effort given to reconditioning and rehabilitation, during and after World War II, in the Army and Navy Reconditioning Programs, and the Physical Medicine Rehabilitation Service in the Veterans Administration Hospitals, as well as some civilian hospitals, where this additional form of medical treatment is being installed.

It is very encouraging and gratifying to those of us who have seen this increasing emphasis on scientifically adapted exercise programs become accepted on a nationwide basis, to scan the record and see that these programs have been planned and developed by the top men in the field of Physical Education.

It was the one-time circus performer, Dr. Dudley A. Sargent, who developed, with the aid of his long-time friend W. L. Coop, many of the remedial or corrective pieces of apparatus now used extensively in the application of therapeutic exercises.

We need to recall that prior to World War II, in the wake of World War I, this same type of program was found in schools, colleges, Y.M.C.A.s, Y.W.C.A.s, Turnvereins, field houses, and athletic fields in many sections of this country.

These programs emphasized alignment of segments. The purpose of alignment of the related segments of the body in normal active patterns of movement is to make possible the normal range of motion of each segment, resulting in the strengthening, developing, and coordinating of the weak and incoordinated parts of the body.

In the firm belief that not only was physical fitness an end-product of activity, but that a great socializing potential is also inherent in pleasurable physical exercise, these pioneers have established some "guide posts" that Corrective Therapy can ill afford to allow to become "hitching posts."

More research by our group is needed. The Association of Health, Physical Education and Recreation is at present 22,000 strong. It is backed by the prestige and financial stability of the National Education Association. From the very beginnings, a section known as the Therapeutic has been active in this Association. This section is composed of those individuals, trained in Physical Education and Health, who are organizing and conducting the corrective physical education programs in our colleges, high schools and the opportunity schools on the elementary and junior high school level throughout the country.

As we come together in our National Convention, having passed another milestone in the rapid growth of our Association for Physical and Mental Rehabili-

(Continued on Page 24)



## THE APTITUDE SHOP IN NEUROPSYCHIATRIC HOSPITALS

(Continued from Page 19)

second, the exact needs and capacities of the patient. These requirements, we believe, define the functions of an aptitude shop. However, since in the proposed unit actual aptitude testing is only a segment of the total mission it would seem logical to broaden its appellation. The designation "Rehabilitation Laboratory" appeals to the author as being descriptive and appropriate.

We may now proceed to an analysis of the task confronting us if we would set up a Rehabilitation Laboratory adaptable to the needs of an effective therapy program. Therapy and selection of therapy is always the prerogative of the physician and so it is important that the personnel of the laboratory be oriented to the idea that the unit is first, last, and always a fact-finding unit—that it has no executive functions. The duty of each aide, instructor, and psychologist is to assemble pertinent facts about the patient and to organize and present them to the physician in a manner that they are immediately useful to him.

The first thing that the prescribing physician must know is what each rehabilitation project has to offer and what minimum requirements it demands. It is highly essential that the minimum requirements of the project be thoroughly understood, for the worst possible mis-assignment is that which demands more than the particular patient can supply and so dooms him to failure and further frustration. The rehabilitation Laboratory then may well initiate its activity with a careful job analysis of every project available in the therapy situation and evaluate each project from the standpoint of demands on the patient.

1. Degree of social adjustment required
2. Degree of specific skill required
3. Physical demands of the project

In the same way each project must be evaluated in terms of what it offers the patient psychologically. An incomplete list of these elements would include:

1. Emotional outlet offered
2. Possibilities of sublimation of unacceptable wishes or urges
3. Possibilities of ego dilatation through group identification or productive work
4. Potentialities for deriving satisfaction from reality as a means of dissipating fantasy
5. Resocialization value
6. Relieving situationally conditioned inferiorities through specific vocational and educational training
7. Potentialities for non-specific relief of tension.

As each project is analyzed along these lines it may

be classified and catalogued in a permanent reference file available to the prescribing physicians. When new projects are developed in the therapy program they should be submitted to the laboratory for classification and listing in the catalogue.

The second service that the laboratory must provide is a survey of the needs, limitations, and potentialities of the individual patient as he enters rehabilitation therapy. Here again the approach is bilateral. The patient's limitations and assets are evaluated from four aspects.

1. Status of socialization
2. Special skills possessed and available
3. Immediate functional intellectual level
4. Physical status

As has been repeatedly emphasized above, the patient's needs must be considered primarily from the psychological and emotional viewpoint. The particular needs that any patient may present under certain conditions are difficult to delimit, but among the more common ones we may list:

1. Free emotional expression
2. Sublimation of unacceptable urges or wishes
3. Feeling of acceptance by and identification with the group
4. Ability to get satisfaction from reality without fear of frustration or rejection
5. Externalization of thinking and feeling
6. Training in a new vocation
7. Relief of tension

It will be noted that the elements in the project analysis correspond to those in the patient analysis. The minimum requirements of the project parallel the limitations and assets of the patient and the psychological characteristics of the project correlate with the emotional and psychological needs of the patient.

These four sets of data provide the information required for proper assignment to rehabilitation therapy. It only remains to bring them together properly. It is at once apparent that the four groups of facts fall into two pairs. As noted above, one pair deals with requirements of the project and assets of the patient, while the other pair describes the psychological needs of the patient. It may be stated empirically that there are two criteria for proper assignment in Rehabilitation Therapy: (1) The assignment must be such that it does not exceed the patient's capacity, and (2) it must satisfy some psychological or emotional need of the patient. Obviously these criteria correspond to the two pairs of data. The data in the first pair fall into two categories, one comprehending the socialization status and the other in-

## THE APTITUDE SHOP IN NEUROPSYCHIATRIC HOSPITALS

cluding mental, physical, and special skill attributes, or in other words the personal status. These two categories must be handled separately. The socialization status of the project must correspond as closely as possible with that of the patient; for if the size of the group in the project is beyond the social capacity of the patient, he will very likely withdraw into himself; and if it is too small, he will not be stimulated to increase his capacity for social integration, but on the contrary, the ever present tendency in psychotics and most neurotics to withdraw from social contacts is enhanced. The category involving personal status is handled differently. Here there are three elements—physical level, mental level, and degree of special skill. Our primary concern in this instance is to insure that the patient has the capacity to succeed in the project; therefore, the maximum demand for an element of the project must not exceed the minimum capacity of the patient in any element. If this specification is met, then the patient's overall capacity will be sufficient to meet the demands of the assignment. This phase of the problem appears to rest on a sound theoretical basis, but before these principles can be applied in practice a way must be found to reduce the operations involved to a formula. Bearing in mind that elements involved fall in two categories, it is logical to utilize two categories of symbols such as letters and numbers. The quantitative weight for any element may then be expressed by position of the symbol in a series. Thus one element may be quantitatively expressed as a, b, c, or d with "a" representing a light or minimal degree and "d" representing great or maximal degree. The numbers 1, 2, 3, 4 may be used for elements in the other category in the same way. An illustration will make the method clear. For this purpose the letters a, b, c, d will be used to indicate degree of socialization required on the project or attained by the patient. The symbol equivalents may be expressed in a table.

Symbol	Project	Patient
a	Individual	Asocial
b	Group of 2 or 3	Mingles passively with small group
c	Small group requiring cooperative effort	Mingles actively with small group
d	Large group requiring cooperative effort	Fully socialized

In similar manner the personal status elements may be symbolized utilizing the ascending numerical series 1, 2, 3, 4 to indicate ascending quantities or degrees

of the element required by the project or attained by the patient. Thus

Symbol	Element	Project Demands	Patient Capacity
1	Physical	Wheelchair	Wheelchair
2	"	Able to walk	Able to walk
3	"	Mild exertion	Mid exertion
4	"	Moderate exertion	Moderate exertion
1	Mental	Mental age 10	Mental age 10
2	"	Borderline normal	Borderline Normal
3	"	Low average	Low average
4	"	None	Average or better
1	Special Skills	Ability to use simple tools	None
2	"	Ability to use ordinary tools	Uses simple tools
3	"	Highly technical	Uses ordinary tools
4	"		Technically trained

To continue with the illustration, a project in horticulture may be analyzed. Inquiry reveals that patients work more or less individually but generally in small groups of three or four. The symbol "b" is appropriate. Physically the work is easy but on occasion calls for mild exertion, and this element is rated "3". The work requires the use of ordinary tools, and so "special skills" is scored "3". Assembling these symbols in the order derived, the formula b-3-3-3 is obtained, and this describes the project in so far as its basic requirements for success are concerned.

An analysis of an hypothetical patient may be carried out in the same way. This patient is observed to spend much of his time reading on the ward but occasionally he carries on a spontaneous conversation with the nurse and on one occasion he took part in a card game with three other patients. His social status symbol is "b". He is a robust, healthy young man and warrants a "4" physically. On routine psychological examination his I.Q. was found to be 110 and so his mental rating is "4". Prior to coming to the hospital he had done some work as an auto mechanic's helper. It may therefore be assumed that he can use ordinary tools and his skill rating is "3". His scores can be assembled into the formula b-4-4-3. Checking this formula against the one for the project it is clear that he can make the necessary social adjustment and no requirement of the project exceeds any rated ability that he has. It can be assumed that the project is within the capacity of the patient and he has a reasonable chance to succeed.

In order to simplify the catalogue of projects it is necessary to simplify the formulae further. Since the socialization level of the project and patient must coincide, it is necessary to retain the symbol of that element. However, for the personal elements it is only necessary that no element on the project be scored higher than the lowest score obtained by the patient on any element. Returning to the illustration the project formula may be reduced from b-3-3-3 to b-3 and the patient formula from b-4-4-3 to b-3.

This simplified formula makes the catalogue of projects very simple indeed. card is made for each project. These cards are first filed under the socializa-

## THE APTITUDE SHOP

tion status symbol, a, b, c, or d and then each of these main groups is arranged under personal element symbol 1, 2, 3, or 4. Thus when a patient has been analyzed and classified b-3, for example, the therapist simply goes to section b of the catalogue and pulls all the cards filed under 3. This gives him all the projects for which the patient can qualify.

It does not appear worth while to attempt to codify the second pair of elements of the full study—that is, the psychological attributes of the project and the psychological needs of the patient. Rather, it would seem simpler and better to list on the project catalogue card the psychological and emotional opportunities offered by the project in the order of their dominance. Similarly the psychological and emotional needs of the patient may be summarized in the psychological work-up developed in the Rehabilitation Laboratory. The therapist can then select from the projects for which the patient is qualified the one apparently most suited to his needs.

As mentioned earlier, the initial function of the Rehabilitation Laboratory is to analyze and catalogue every project available to the Rehabilitation Department. Thereafter its activities will be chiefly concerned with the analysis of patients coming for their initial assignment.

Of equal importance in the analysis of the patient is the practical testing in the laboratory. In the original analysis this is important in determining degree of special skill retained by the patient and in determining his socialization status in the work milieu. Further, although we know that psychological evaluations are usually valid they may sometimes be misleading. Therefore after the classification has been accomplished the doubtful cases, and many others, can be given a trial on a project or projects similar to those recommended as suitable, and further observations can be made by the instructor.

After the completion of the testing, trials, and classification of the patient, the data are assembled in a brief laboratory report and transmitted to the physician in charge of the case who, after consulting the catalogue of projects and applying his clinical judgment, is in the best possible position to make a scientific assignment in Rehabilitation Therapy.

### Summary

Experience has shown that an Aptitude Shop can be of great value in the Manual Arts Therapy Section even when it consists of only a shop where patients can try out their abilities under the observation of an instructor. The addition of a psychologist to this unit enhances its value to Manual Arts Therapy and extends its usefulness to other sections as well. From theoretical considerations it appears that a systematic analytical approach to both patients and projects can bring about the final maturity

of the aptitude shop to a Rehabilitation Laboratory.

This approach calls for the evaluation of patients and projects in comparable areas and the establishment of a system whereby patients and projects can be scientifically matched and the results checked by practical trial.

## CORRECTIVE PHYSICAL EDUCATION—

(Continued from Page 21)

tation, we will do well to face the problems of our Association with new courage and determination to carry the torch, handed to us by these undaunted pioneers, until our objective—the physical and mental rehabilitation of those severely handicapped by accident or disease—has been accomplished, and those severely handicapped have again taken their place in our society to make their contribution to our survival in the critical years just ahead.

Many commodities may soon be in short supply. Many people are becoming so confused that the importance of conservation, not only of our material, but also of our human resources, becomes of great significance in these trying times.

Let us formulate and declare some unified objectives, and as members of the Association for Physical and Mental Rehabilitation, work with the zeal and determination that will enable our organization to make the valuable contribution to the national economy that it is so capable of doing.

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# THE PROGRESS NOTE PROBLEM

By LOUIS M. FRAZIER, JR.

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What should be included in my progress notes? Should they be brief? How often should I write notes? Do you want my impression or do you want just the facts? Why should I write notes? No one reads them.

These questions and many other similar questions have been asked repeatedly at conferences, meetings, and in everyday work situations by men and women on the rehabilitation team. Answers have been varied. In some instances the answers have been lengthy to the point of being vague, and few specific instructions have been offered.

Misunderstanding will continue to exist where no clear-cut plan for writing progress notes has been established. Progress notes can improve and contain valuable information when the therapists and physicians reach a common understanding of what will be considered relevant.

The progress note problem was minimized in the Corrective Therapy Section at Kennedy Hospital by the method described here. The members of the section agreed upon the information that they wanted to include. The Chief, Physical Medicine Rehabilitation and the ward physicians were asked what type of information they wanted about the patients for whom they were prescribing treatment. All of the ideas were assimilated. The outline itself is short and simple, but a few things to consider before writing the note were supplemented. They are the pertinent facts which the therapists and physicians wanted to include.

The type of progress note outline that is used follows:

1. Patient's name, Register number, Ward number.
2. Date.
3. Statement of progress, lack of progress or unusual occurrence.
4. Initials or name of therapist writing the note.

The items listed below which are applicable should be incorporated into the note:

1. What is specifically prescribed?
2. Condition of the patient at the time of initial treatment.
3. Any change in the condition of patient.
4. Treatment schedule (time of day, frequency of treatment, etc.).

Reviewed in the Veterans Administration and published with the approval of the Chief Medical Director. The statements and conclusions published by the author are the result of his own study and do not necessarily reflect the opinion or policy of the Veterans Administration."

5. Attitude and attendance record.

6. Interruptions in treatment (L.O.A., surgery, any change in clinical status).

This was not the complete solution to the problem. Continuous attention was directed toward improvement of the progress notes. Training in the use of medical terms which could replace descriptive phrases and sentences was instituted. A few in-service training classes were conducted but most of the training was achieved through on-the-spot instruction. Notes that needed revision were discussed with the therapist and changes were made.

Experience in our situation indicated that progress notes to be complete should be recorded at the time the progress occurs. If an attempt is made to record progress "a few days later," further progress may have occurred and some important fact overlooked. When no change is noted within a month, a report to that effect is made and the reason is given if it is known.

Generally speaking, impressions are of little value. However, if an impression will emphasize progress or a change, it should be included. The therapists and the physicians are interested primarily in the facts. Did Joe move independently from his crutches to the wheelchair or did he fall in an attempt? Can he walk ten feet or ten yards? Is his gait normal or abnormal? Progress notes do not have to be long to be complete. A few well chosen words mean more than general statements. State the facts clearly and concisely.

The progress record of a given patient becomes valuable when it can be compared with the records of other patients afflicted with similar disabilities. The report of progress is valuable also to the physician who became aware of changes in the patient which may indicate the necessity to increase treatment, decrease treatment, or discontinue treatment.

In summary, a clear cut policy for writing progress notes should be established. There must be common understanding between the physician and therapist as to what progress notes should include. An outline to serve as a guide for the therapist will aid in standardization of notes for completeness and form. Therapists have to be trained to write good progress notes. Continuous on-the-job instruction has been proven in many fields. Notes should be written when changes occur and as often as they occur. They should be factual. They furnish a wealth of information for research. Progress notes indicate to the physician when treatment should be changed.

# A SYSTEM OF WRITING PROGRESS REPORTS FOR GENERAL MEDICAL AND SURGICAL PATIENTS IN THE CORRECTIVE THERAPY PROGRAM

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This paper has been compiled for the purpose of standardizing progress notes prepared by Corrective Therapists. In the past the list of categories included in the report "Corrective Physical Rehabilitation—Observational Reports" has aided the therapist in the writing of progress notes for the neuropsychiatric patient. Now there is a need for a list of criteria which will outline in a simple manner the essentials of a progress note for the general medical and surgical patient.

The information that these notes relay to the physiatrist and the ward physician determines the patient's capabilities and helps them to prescribe the treatment for the remainder of the hospitalization period. Since these notes eventually become a permanent part of the patient's corrective therapy chart they should be informative, concise and complete. To insure completeness the instructor should include in his report as many of the categories as possible. Emphasis in all categories should be placed upon the functional ability of the patient, to distinguish the report from the individual muscle testing records. In all instances abbreviations should be avoided.

Progress notes should be forwarded to the referring physician periodically; a note every two or three weeks is considered the minimum except in certain long term patients, e.g., hemiplegics, multiple sclerosis, etc. A special note should be written when there is a sudden or unusual change in the patient's condition or ability; a final note is filed when the patient is discharged from a program or from the hospital.

All reports should be typed in duplicate. The original is forwarded to the ward to become a permanent part of the clinical record and the duplicate is attached to the patient's prescription and remains on file in the Corrective Therapy Clinic.

This outline has been prepared primarily for the therapist. An attempt has been made to employ a definite and orderly system in the hope that it will serve as a practical reference in the preparation of these progress reports.

\* Reviewed in the Veterans Administration and published with the approval of the Chief Medical Director. The statements and conclusions published by the authors are the result of their study and do not necessarily reflect the opinion or policy of the Veterans Administration.

## ESSENTIAL ELEMENTS OF PROGRESS NOTES

- I. Full name. Ward number. Date.
- II. Attendance—regular, irregular, etc.
- III. Treatment.
  - A. Type of treatment:
    1. Reconditioning—General
    2. Remedial—Specific; i.e., definite muscle groups, upper or lower extremities, shoulder girdle, pelvic girdle, etc.
    3. Postural exercises:
      - a. Preventive
      - b. Corrective
    4. Pre-ambulation exercises.
    5. Ambulation training.
    6. Breathing and relaxation exercises.
  - B. Type of exercise:
    1. Passive
    2. Active assistive
    3. Active:
      - a. Isometric
    4. Active resistive:
      - a. Concentric
      - b. Eccentric
  - C. Fundamental movements:
    - Extension
    - Adduction
    - Pronation
    - Dorsiflexion
    - Elevation
    - Rotation
    - Hyperextension
    - Compression
    - Inversion
    - Radial flexion
    - Flexion
    - Abduction
    - Supination
    - Plantar/Palmar flexion
    - Depression
    - Circumduction
    - Opposition of thumb
    - Expansion
    - Eversion
    - Ulnar flexion

# A SYSTEM OF WRITING PROGRESS REPORTS FOR GENERAL MEDICAL AND SURGICAL PATIENTS IN THE CORRECTIVE THERAPY PROGRAM

## D. Exercise tolerance:

1. Mild—light
2. Moderate
3. Heavy—strenuous
- 4.—On:
  - a. Bed
  - b. Mat
  - c. Apparatus (state type)
  - d. Ambulation

## IV. Effect of treatment

### A. Functional strength and/or ability:

1. Of muscle groups
2. Of fundamental movements
3. Of extremities

### B. Joint range.

### C. Coordination:

1. General: body control—
  - a. on mat
  - b. in sitting position
  - c. in erect position
  - d. in kneeling position
2. Specific define part of the body, i.e., arm hand, etc.

### D. Functional ambulation ability:

1. Posture
2. Gait
3. Activities
4. Endurance

### E. Self-care activities:

### F. Treatments discontinued because:

1. Patient on Leave of Absence (depending on hospital policy).
  - a. Treatments resumed on request from ward physician.
2. Change in clinical status.
  - a. Treatments resumed on request from ward physician.
3. Patient has received maximum benefit from program, as determined by ward physician or physiatrist.
4. Patient refuses to participate in prescribed program.

### G. Attitude toward treatment:

1. Cooperative—uncooperative.
2. Conscientious—indifferent.
3. Enthusiastic—bored.
4. Lacks confidence—in self, in instructor.

## V. Therapist's initials.

### TYPICAL PROGRESS NOTES

Jones, John Ward 77B 4/1/51 (Quadriplegia)

Patient attends Corrective Therapy Clinic twice daily for reconditioning and remedial exercises. In the morning patient receives active assistive, active and active resistive exercises to all fundamental move-

ments of the trunk and upper and lower extremities. Muscle tone and strength have shown good improvement in all movements with the exception of those of the hands and ankles. Leg movements are jerky but controllable except when affected by spasm. In the afternoon patient takes part in mat exercises to improve body control and gross muscular movements. He can turn from side to side, prone to supine, supine to prone and come to the sitting position from the supine position. Patient can attain four point position (hands and knees) and can crawl up to ten feet both forward and backward. All of these activities are done slowly and with some difficulty. Patient can do push-ups with difficulty with limitations due to spasm. He is a hard conscientious worker. The instructor feels that the patient's present physical condition indicates that he is ready to begin ambulation training. Such training will be started when prescribed by the ward physician or the physiatrist.

C.P.R.

Lion, Leo Ward 14B 4/14/51 (Hemiplegia)

Patient has reported for Corrective Therapy treatments daily since referral on 12/29/51. He is receiving hemiplegic training, remedial exercises to left upper and left lower extremity, and ambulation training. Patient has no active movements of the left arm or shoulder. Passive movement of the upper extremity is limited by pain at extreme range of motion. Patient can actively flex and extend left leg against light manual resistance. Adduction of the hip is strong but abduction can be accomplished only with assistance. There is no active dorsiflexion of the ankle. Passive stretching of the Achilles Tendon moves ankle to 90 degrees.

Patient can ambulate up to 100 yards with the aid of a cane, however his gait is poor and he has not yet learned to permit his weight to fall on his left leg. It is expected that patient's gait will improve with further instruction when his drop-foot brace is available. Training in other ambulation activities has just begun. It is suggested that patient begin to ambulate on the ward.

Patient can get up from his wheelchair, sit up in bed and move from bed to wheelchair unassisted. He is now learning to dress and undress himself. All toilet activities can be accomplished without assistance.

I.N.S.

Smith, Peter, Ward 66C 4/17/51

Corrective Therapy treatments have been discontinued because of change in clinical status of patient. Treatments will be resumed either on the ward or in the clinic upon request from the ward physician or the physiatrist.



# COMPILATION OF PAST JOURNAL ARTICLES

Compiled by:  
SAM BORUCHOV  
Editor-in-Chief

RUTH H. CORNELIUS  
Setauket, L. I., N. Y.

A file containing all the articles which have appeared in the past Journals has been compiled. It is hoped that the following information may be of assistance to those wishing to use these articles for reference. We have noted the authors, the title of

the article and the date of the publication in which such items have appeared.

Anyone wishing a back copy of a Journal may write to the Editor, Mr. Sam Boruchov.

The cost is One Dollar per issue.

MARCH, 1947		AUTHOR		TITLE	
LOUIS B. NEWMAN, M.D. Chief, Med. Rehabil. Ser. Veteran's Administration Hosp., Hines, Ill.		DEAN, RUSSELL Executive Officer, Medical Rehabilitation, Veteran's Administration, Washington, D. C.		"Corrective Physical Rehabilitation in Relation to Other Therapy"	
ROLAND C. SCHWARTZ Former Comm. Rehabilitation Physical Training Instructor School, ETO, and Chief Consul. Corr. Phys. Reconditioning, ETO now Exec. Officer of the Medical Rehabilitation Section, V.A. Branch Office #7. and JOHANNES TIMMERMAN Executive Officer, Medical Rehabilitation, Service, VA Hospital, Hines, Illinois.		FRAZIER, LOUIS M., JR. Training Assistant, Corrective Therapy, VAMTG, Kennedy Hospital, Memphis, Tennessee.		"A Method of Moving from a Prone Position to Standing Position Using Crutches Only"	
GEORGE STAFFORD, M.D. Professor Physical Education University of Illinois.		LUOMA, FRANCIS G. Chief, Corr. Physical Rehab., Coral Gables, Florida.		"Report on Veterans Administration Course of Instruction in Corrective Physical Rehabilitation"	
PAUL ROLAND Chief, Corr. Phys. Rehabilitation Veteran's Administration Hospital, Danville, Illinois.		MANTOVANO, LOUIS F. Corrective Therapy, VAH, Manhattan Beach, Brooklyn, New York.		"The Precision Walker for Gait Training"	
HAWLEY, PAUL R., M.D. Chief Med. Director Dept. Med. & Surgery.		APPEL, MURRAY L. and METZ, JOHN, JR. Corrective Therapists, Bronx, VA Hospital, New York, N. Y.		"Corrective Therapy Activities for Pre-Frontal Lobotomies"	
BORUCHOV, SAM Chief, Rehabilitation Ser. V.A. Hospital, Northport, L. I., New York.		DONALD A. COVALT Asst. Med. Director for Phys. Medicine Rehabilitation, Dept. Medicine & Surgery, V.A., Washington, D. C.		"Corrective Therapy: Its Achievements and Future"	
RUSK, HOWARD A., M.D. Chairman, Dept. Reh. N.Y.U. College of Medicine Assoc. Editor, N. Y. Times Cons. in Med. Rehab. to the Medical Director, Veteran's Adm.		C. D. MOLONDER Dir. Dept. Phys. Medicine, Michael Reese Hospital, Chicago, Illinois.		"Treatment of Hemiplegia"	
ROLAND C. SCHWARTZ Exec. Officer Branch 7, Medical Rehabilitation Section, V.A.		GEORGE STAFFORD, M.D. Consultant, V.A.		"The Need for Scientific Therapeutic Exercise in the Rehabilitation Program"	
KARL K. KLEIN Asst. Prof. Phys. Ed. Ithica College, Ithica, N. Y.		COBB, JACKSON B. and LA SCHUMA, HAROLD Veteran's Administration Hosp., Columbia, S. C.		"Heavy Resistance Exercise: A Study of Various Procedures Designed to Increase Strength"	
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BURR S. ZACHARY & Staff Neuropsychiatric Hospital, West Los Angeles, 25, Cal.		BADER, CHARLES Chief, Corr. Therapy, Veteran's Adm. Center, Togus, Maine.		"Corrective Therapy on the Hemiplegia Ward"	
TIMM, OREN K., M.D. Clinical Director, Veteran's Administration Hosp., Danville, Illinois.		DAVIS, P. R. Exec. Asst. Physical Med., Veteran's Hospital, Columbia, South Carolina.		"Emotional Control Through a Recreational Activity"	
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ROLAND, PAUL Chief, Corr. Physical Rehab., Veteran's Administration Hosp., Danville, Illinois.		HELAND, FLOWERS, M.D. Chief N. P. Service & Cor. Therapists, Leo Berner, Murray Crystal, Murray Appel, John Metz, Bronx, V.A. Hospital, N. Y.		"Corrective Therapy in Terms of Available Hospital Beds"	
KRAMER, ROBERT Corr. Physical Rehab. Instructor, Veteran's Administration Hosp., Fort Lyon, Colorado.		VINCENT BRUNO JULIUS LEVIN DANIEL BENNETT Halloran V.A. Hospital, Staten Island, New York.		"Role of C. T. in Pre-Frontal Lobotomy Cases"	
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# COMPILATION OF PAST JOURNAL ARTICLES

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**TITLE**  
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"Long Bed Crutches"

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Director of Children's Div., Men-  
ninger Foundation, Topeka, Kansas.  
DANIELS, ARTHUR S., Professor  
Dept. of Phys. Education, Men's  
Division, Ohio State University.

"Physical and Corrective  
Therapy"  
"General Need for Medical Re-  
habilitation"  
"Personality Study Outline for  
Corrective Therapists"  
"College Physical Education for  
the Veteran with a Disability"

## OCTOBER, 1948

MORGAN, CECIL W.  
Office of the Surgeon General  
and  
STRICKLAND, B. A., JR., Lt. Col.  
Office of the Surgeon General  
Department of the Army  
PETERSON, KJELL J.  
Pres. Metropolitan Life Insurance:  
Athletic Association,  
New York City, N. Y.  
DAVIS, JOHN EISELE, Sc. D.  
Medical Rehabilitation  
Veterans Administration  
Washington, D. C.  
MONTGOMERY, MAX M., M.D.  
Asst. Professor of Medicine  
Univ. of Illinois College of Medicine  
BRAUN, LOUIS  
and  
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Chief, Reintegrative Research Serv.  
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Northport, Long Island, N. Y.

"The Physical Reconditioning  
Program of the Army"  
"Practical Aims for Corrective  
Therapy"  
"Corrective Physical Rehabilitation  
for Neuropsychiatric Pa-  
tients"  
"Arthritis"  
"Corrective Therapy on the Sur-  
gical Wards"

## DECEMBER, 1948

JOHN EISELE DAVIS  
Chief, Corrective Therapy, Vet-  
eran's Administration.  
JOHN L. BUNKER  
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Chief, Cor. Therapy, V.A. Hos-  
pital, Canadagua, N. Y.  
and  
DANIEL DANCIC, M.D.  
Chief, Physical Med. Rehab., V.A.  
NPT, N. Y., V. A.

"Research Trends in Corrective  
Therapy"  
"Water Polo for Paraplegics"  
"The Application of Corrective  
Therapy Procedures in the  
Treatment of Post-Leuctomy Pa-  
tients"

## FEBRUARY, 1949

MURRAY CHRYSAL  
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Corr. Therapists Veteran's Adm.  
Hospital, 130 Kingsbridge Road,  
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the Army Tuberculosis Rehabilitation  
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Springfield, Massachusetts

"Exercise Therapy in Relation  
to the Toxic Effects of Strepto-  
mycin"  
"Physical Medicine Rehabilitation  
from the Viewpoint of  
Corrective Therapy and Adapted  
Sports"  
"Some Preliminary Notes on  
the Use of a Motor Driven  
Ergometer in the Treatment of  
the Neuropsychiatric Patients in  
Connection with Milieu Therapy"  
"The Role of Manual Arts  
Therapy in a Medical Rehabili-  
tation Program"  
"Objective Strength Tests of  
Affected Muscle Groups In-  
volved in Orthopedic Disabili-  
ties"

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LESLIS BLAU, M.D.  
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stitute.  
KARL K. KLEIN  
Asst. Professor Physical Education.

**TITLE**  
"A Physical Medicine Program  
in the Treatment of Multiple  
Sclerosis"

WILLIAM J. ZILLMER  
Chief, Corr. Therapy, V.A. Hos-  
pital, Fort Benjamin Harrison, In-  
diana.  
VINCENT J. BRUNO  
Supervisor, C. T. Halloran V.A.  
Hospital, Staten Island, New York.

"Mental Rehabilitation Boards  
in N. P. Hospitals"  
"Orientation and Foot Travel  
at the Industrial Home for the  
Blind"  
"Survey Report on a Potential  
Advanced Curriculum of Study  
for Corrective Therapy"  
"The Application of Corrective  
Therapy Procedure in the Pre-  
Prosthetic Treatment of Am-  
putees"  
"Ambulation for Paraplegics"

## JUNE, 1949

DAVIS, JOHN E.  
Chief, Corr. Therapy, V.A., Wash-  
ington, D. C.  
KRAUS, HANS, M.D.  
Institute of Rehab., N. Y. Uni-  
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V.A., Chillicothe, Ohio.  
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GREENWOOD, EDWARD, M.D.  
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GORDON, EDWARD E., M.D.

"Corrective Therapy, an Ori-  
entation as to its Function and  
Meaning"  
"Therapeutic Exercises in Re-  
habilitation"  
"Therapeutic Exercises for Mul-  
tiple Sclerosis"  
"The Integration of Group Ac-  
tivity and Group Therapy"  
"Principles of Emotional Re-  
habilitation"  
"Principles of Emotional Re-  
habilitation"  
"Rehabilitation of the Neuro-  
psychiatric Patient"  
"The Neuropsychiatric Patient"  
"Some Pharmacodynamic Ef-  
fects of Muscular Exercise"

## AUGUST, 1949

ROLAND, PAUL  
Chief Corr. Therapy  
MASON, EARL W.  
Chief Corr. Therapy, Nichols V.A.  
Hospital, Louisville, Kentucky  
and  
KOSKI, EDWARD Z.  
Corr. Therapist, Louisville, Ky.  
RUSK, HOWARD A., M.D.

"An Exploratory Training Tech-  
nique for the Re-education of  
Catatonics"  
"An Exploratory Training Tech-  
nique Using a Group Procedure  
for Relaxation"

DAHMEN, CARL  
Orthopedic Technician  
HARRIS, W. L., M.D.  
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Northport, Long Island.

"New Program Provides Aid  
for Physically Handicapped"  
"Orthopedic Braces for Lower  
Extremities"

EISERT, OTTO, M.D.  
Chief Phys. Med. Rehab., Manhat-  
tan Beach V.A. Hospital, Brook-  
lyn, New York.

"Rehabilitation of the Chronic  
Mentally Ill"

SCHEFFER, HERBERT, M.D.  
Director Bureau Medicine,  
New York City, New York.

"Rehabilitation in the New  
York City Hospitals"

## OCTOBER, 1949

KNUDSON, A. B. C., M.D.  
and  
DAVIS, JOHN EISELE, Sc.D.  
Department of Med. & Surgery,  
Veteran's Administration, Washing-  
ton, D. C.  
BUCHANAN, JOSEPHINE J., M.D.

"Medically Prescribed Exercises  
for Neuropsychiatric Patients in  
the Veteran's Administration"

"Rehabilitation of the Patient  
with Chronic Poliomyelitis"

# COMPILATION OF PAST JOURNAL ARTICLES

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HOLLANDER, MANNY  
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STEIN, LEO LEN

**TITLE**

"The Role of the Chronic In-  
dividual in Modern Society"

"Corrective Therapy in the  
Treatment of the Lower Ex-  
tremity Amputee"

"Rehabilitation of the Tuber-  
culosis"

"Psychiatric Nomenclature for  
Rehabilitation Personnel"

**AUTHOR**

ZIMMER, HOWARD, M.A.  
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FLAHERTY, BERNARD, M.D.  
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RASCH, PHILLIP J.  
RANKIN, CLINT  
DePALMA, JOHN  
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SANDERS, E. M.  
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ROCKSTROH, HENRY J.,  
Capt. M.S.C.  
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WINKLEBLECH, DONALD R.  
1st Lt. U.S.A.F.R. Asst. Chief  
Physical Reconditioning.

SPAR, HARRY  
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Blind.

**TITLE**

"A Series of Temporary Lower  
Extremity Prostheses"

"Corrective Therapy as It Re-  
lates to the Neuropsychiatric  
Patient"

## AUGUST, 1950

"Needed Research in the Field  
of Corrective Therapy"

"The Role of Therapeutic Danc-  
ing in a Corrective Therapy  
Program"

"Preliminary Report of a Sur-  
vey of the Research in the  
V.A. Hospitals"

"Remedial Aquatics at Oliver  
General Hospital"

**DECEMBER, 1949**

KNUDSEN, A. B., M.D.  
Chief Physical Rehabilitation,  
Veteran's Administration  
Washington 25, D. C.

RUDD, J. L., M.D.  
MARGOLIN, REUBEN J., M.A.

TALBOT, HERBERT S., M.D.

O'KEEFE, JOHN J.  
Chief Vocational Rehab.  
and  
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Physical Med. Rehab. Service  
and  
GOLDBERG, JACOB, M.D.  
Physical Med. Rehab. Service

MORROW, ROBERT S.  
Veteran's Administration Hosp.,  
Bronx, New York.

"Corrective Therapy a Medical  
Synergist in Total Rehabilita-  
tion"

"Rapid Rehabilitation of Back  
Cases"

"The Approach to Rehabilita-  
tion in Paraplegics"

"The Rehabilitation Board in a  
Veterans Administration Tuber-  
culosis Hospital"

"The Clinical Approach in Vo-  
cational Rehabilitation"

SANDERS, E. M.  
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ROCKSTROH, HENRY J.,  
Capt. M.S.C.  
and  
WINKLEBLECH, DONALD R.  
1st Lt. U.S.A.F.R. Asst. Chief  
Physical Reconditioning.

SPAR, HARRY  
Director, 520 Gates Avenue, Brook-  
lyn 16, Industrial Home for the  
Blind.

GRADUATE SCHOOL OF  
PHYSICAL THERAPY

"Preliminary Report of a Sur-  
vey of the Research in the  
V.A. Hospitals"

"Remedial Aquatics at Oliver  
General Hospital"

"Instructions in Physical Ori-  
entation and Foot Travel"

"Items That May Assist Polio  
Patients to Become Indepen-  
dent"

## OCTOBER, 1950

ABRAMSON, ARTHUR S.  
Phys. Med. Rehab.  
Veterans Hospital, Bronx, N. Y.

INDUSTRIAL SCHOOL  
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and  
BADER, CHARLES

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YAMSHON, L. J., M.D.  
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and  
NEILSON, J. M., M.D.  
and  
SCHULTZ, DONALD A., Ph.D.  
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Birmingham, California

WERTZ, STANLEY H.  
Corr. Therapist, Kennedy Hospital  
Memphis, Tenn.

JENKINS, RICHARD L., M.D.  
Chief Research Section  
Psych. & Neuro. Division  
U.S.V.A., Washington, D. C.

"Principles of Bracing in the  
Rehabilitation of the Para-  
plegic"

"Instruction in Physical Ori-  
entation and Foot Travel"

"Outdoor Gymnasium for Cor-  
rective Therapy at Togus Vet-  
erans Administration Neuropsy-  
chiatric Hospital"

"Activity and Aphasia Therapy"

"The Use of the Pulley Weights  
in the Treatment of the Multi-  
ple Sclerosis Patient"

"Goal-directed Activities in the  
Treatment of Schizophrenic Pa-  
tients"

**FEBRUARY, 1950**

DEAVER, GEORGE G., M.D.  
Lenox Hill Hospital, Cerebral Palsy  
Pre-School Center.

KUNHEN, JOAN C., Co-Ordinator  
Lenox Hill Hospital, Cerebral Palsy  
Center, New York, New York.

WILLIAMS, R. C.  
GRUBER, KATHERINE  
BLEDSOE, C. W.  
Blind & Seeing Orientators

KAYRUCK, SAMUEL  
GOHEEN, HOWARD W.  
Standards & Test Unit, Veteran's  
Adm., Washington, D. C.

RUDD, J. L., M.D.  
MARGOLIN, REUBEN J., A.M.  
ROSE, CHARLES L., A.M.

FILLIMORE, R., M.D.  
Dept. of Physical Medicine  
and  
OLDHAM, J. W., Supervisor  
Prosthetic Shop, V.A. Center, 6167,  
Temple, Texas.

"Clinical Aspects of Cerebral  
Palsy"

"The Therapeutic Value of Re-  
ciprocal Motion Skills"

"Physical Medicine Rehabilita-  
tion of the Blind"

"The Construction of Written  
Tests in the Selection of Cor-  
rective Therapists"

"Effectiveness of the Hospital  
Conference in Rehabilitation"

"Supplemental Management of  
Post-Phlebotic Edema"

## APRIL, 1950

KESSLER, M. D.  
and  
ARTHUR S. ABRAMSON, M.D.  
Physical Med. Rehab., Veterans  
Hospital, Bronx, New York.

CLARKE, HARRISON H.  
BAILEY, THEODORE L.  
Physical Ed. Research  
Springfield College

GRANT, IRENE, Chief  
Social Service Division  
Central Office, V.A.

"The Rehabilitation of the  
Paraplegic"

"Strength Curves for Fourteen  
Joint Movements"

"Some Values in Mutual Con-  
sultation Between Corrective  
Therapists and Social Workers"

DEAVER, GEORGE G.

WERTZ, STANLEY H.  
Corr. Therapist  
V.A.M.T.G. Kennedy Hosp.  
Memphis, Tenn.

"The Rehabilitation of the Hem-  
iplegic Patient"

"Basic Exercises in the Treat-  
ment of Multiple Sclerosis and  
Similar Diseases of Neuromus-  
cular Dysfunction"

## FEBRUARY, 1951

GREGG, ALAN, M.D.  
Medical Director, Rockefeller Foun-  
dation, New York, New York.

McCLOY, C. H.  
Research Prof., State University,  
Iowa.

DAVIS, JOHN EISELE  
Chief Corr. Therapy  
V.A., Washington, D. C.

**JUNE, 1950**

"The Beginnings of Health"

"Corrective Therapy for the  
Normal Person"

"The Present Educational Chal-  
lenge and Opportunity in Cor-  
rective Therapy"

RUDD, J. L., M.D.  
Veteran's Adm. Hospital  
West Roxbury, Mass.  
and  
MARGOLIN, REUBEN J., Ed.D.  
Formerly Chief Corr. Th.  
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MAZET, ROBERT JR., M.D.  
and  
BARCLIFF, ELDRED L., B.S.

MEISLIN, JACK, M.D.  
Chief Phys., Med. Rehab.,  
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"The Therapeutic Value of the  
Punching Bag in Physical and  
Mental Rehabilitation"

"Wadsworth Footboard"

"Role of the Physical Medicine  
Rehabilitation Co-Ordinator in  
Psychiatric Hospitals"



# COMPILATION OF PAST JOURNAL ARTICLES

FEBRUARY, 1951

## AUTHOR

## TITLE

EDMAN, LEON E.  
Asst. Chief, Corr. Th.

"Some Considerations in the  
Evaluations of Self Care"

KABAT, HERMAN, M.D.  
Medical Director  
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Vallejo, Calif.

"Studies on Neuromuscular Dys-  
function XIII. New Concepts  
& Techniques of Neuromuscular  
Reeducation for Paralysis"

MANSON, P. MORSE, Ph.D.  
Chief Voc. Rehab. Education,  
Long Beach Veterans Hosp.,  
Long Beach, California

"The Dynamics of Rehabilita-  
tion"

APRIL, 1951

OZARIN, LUCY, M.D.  
Asst. Chief, Hosp. Psychiatry Sec.  
Psychiatry and Neurology Div.

"Corrective Therapy in the Psy-  
chiatric Hospital"

ZIMMERMAN, S. L., Lt. Col., M.C.  
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Columbia, South Carolina

"Cooperate to Rehabilitate"

and

DAVIS, PHIL  
Exec. Asst. Physical Med. Rehab.  
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MACKEY, RICHARD T., Ed. D.  
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"The Physically and Psycho-  
logically Handicapped Get Their  
Chance"

McHUGH, CHARLES W.  
Corr. Therapist  
VAMTG Kennedy Hospital  
Memphis, Tennessee

"Development of Devices for  
Self-Feeding of the Quadriplegia  
Patient"

STEWART, MARCUS, M.D.  
Campbell Clinic  
Memphis, Tenn.

"Remedial Exercises and Re-  
habilitation in Back Injuries"

SLATER-HAMMEL, ARTHUR T.  
Assoc. Prof. Physical Education  
Indiana University  
Bloomington, Indiana

"Transfer of Exercise as a  
Therapeutic Tool"

*Convention Greetings*

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3856 9th Ave., Cor. 207 St.,

New York 34, N. Y.

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Tom Ryan—Executive Assistant

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Ed Mecchella

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## **Paralyzed Veterans Ass'n**

**BIRMING CHAPTER**

**Long Beach V.A. Hospital**

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Independence Hall  
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## **Veterans Administration MEDICAL TEACHING GROUP**

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**Louis M. Frazier, Jr.**

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**BETTY NORRIS**

**LEE WILSON**

**HARLAN WOOD**

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**CHARLES LACEY**

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## **PENNSYLVANIA**

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**Irvin Blender**

**William Cully**

**Albert Pascal**

**Emil W. Weber, Jr.**

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## Physical Medicine & Rehabilitation Service

VETERANS ADMINISTRATION HOSPITAL

HINES, ILLINOIS

LOUIS B. NEWMAN, M.E., M.D.

Chief, Physical Medicine and Rehabilitation Service

LOUIS GEREK, M.D.    MAXWELL D. FLANK, B.S., M.D.    GEORGE BARNETT, B.A., M.D.

JAMES N. BURROWS

Executive Assistant

### CORRECTIVE THERAPY SECTION

CARL C. PURCELL

NORMAN TENNER  
FLORIAN SURDYK  
JOSEPH MYSZA  
WALTER OLENEK  
OSCAR OLIVIA  
JOHN CEDARBERG  
JACK P. KLEIN

MELVIN SADER  
CARL SCHWARTZ  
PORTER MYRICK  
F. NORMAN ROCHE  
LEONARD OSZAKIEWSKI  
ROLAND GAGNON  
DONALD BLESS

HARRY HICKS  
WILLIAM RAUPP  
ROBERT ARLEN  
LEO BERGER  
LLOYD WEINBERG  
CLOVIS SEMMES  
WILLIAM ROSENTHAL

MARVIN SIEGEL  
WALTER POZER, JR.  
HENRY CLAY  
A. JAMES ENZINNA  
ROBERT DERMODY  
ALBERT SIMMONS  
RAYMOND SCHMIDT

### BLIND REHABILITATION SECTION

RUSSELL C. WILLIAMS

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ALFORD CORBETT  
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CLARENCE BUGIELSKI  
RICHARD RUSSO

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FRANKLIN WOOD  
PETER GOTFRYD  
EDWARD POLFUS

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*to the*  
Association for Physical and Mental Rehabilitation  
*from the*  
NEW YORK STATE CHAPTER

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Secretary — Mario Andriola

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NEW ENGLAND CHAPTER  
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Association for Physical and Mental Rehabilitation

THE SOUTHERN CALIFORNIA MEMBERS  
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CALIFORNIA CHAPTER  
*in the*  
Fifth Annual Convention of the  
Association for Physical and Mental Rehabilitation  
*to be held at the*  
HOLLYWOOD ROOSEVELT HOTEL  
Los Angeles, California  
JULY 3, 4, 5, and 6 — 1951

GEORGE DEVINS  
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MERTON OLSON  
LAWRENCE WEEKS  
GEORGE WOOD  
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ALDO ROMITI  
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BURR ZACHARY  
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JOSEPH TOACHES  
CLINT RANKIN  
FRED O'BANION  
GREG BRETT  
HAROLD BRENNER  
PHILIP RASCH  
BEN REINHARDT  
SAM COHEN  
ERNEST MILNE

MURRAY LEVITTA  
RICHARD FOWLER  
JOHN BUNKER  
JOHN DePALMA  
HOWARD LEITMAN  
BERNARD WEBER  
MONT HAMILTON  
NORMAN LERMAN  
BRUCE CONNOR  
ROBERT FLANEGIN

## BOOK REVIEW

*Principles of Abnormal Psychology: The Dynamics of Psychic Illness*—by A. H. MASLOW, Ph.D., and DR. BELA WITTELMAN. Published by Harper & Brothers. Price \$5.00. 665 pages.

Here is a revised edition of Maslow and Wittelmann's *Principles of Abnormal Psychology*, one of the leading basic texts in abnormal psychology since its publication eleven years ago. One of the features of the book has been the unique combination of the experimental-academic and clinical-medical backgrounds of its two authors—Dr. Maslow, a teacher of psychology, and Dr. Wittelmann, a practicing psychiatrist. Here is a book that the doctor and therapist will find is not a conventional textbook but a dynamic, vibrant textbook of psychology. In this volume, human conduct, motivation and dynamics are discussed in relation to actual patients in real situations. Particularly extensive were the revisions in the sections on schizophrenia, psychosomatic syndromes and psychotherapy of adults. It is an up-to-date integrated picture of what is now known of the psychologically disturbed individual.

*Leg Amputee: Pre-Prosthetic Training* by SIGNE BRUNNSTROM and DONALD KERR with an introduction by DR. H. H. KESSLER. Rehabilitation Series No. 3. The Kessler Institute for Rehabilitation, Pleasant Valley Way, West Orange, N. J. Forty-four pages with illustrations. 1951.

The booklet is abundantly sprinkled with illustrations concisely explained. The authors are both experienced in the field of rehabilitation, particularly for the amputee. Dr. Kessler has written the introduction in which he notes the qualifications of the authors and the importance of amputee rehabilitation. Most of the text is good and nothing has been added that is new in leg amputee rehabilitation excepting the hopping technique. Question is raised on the hopping technique since it is in a sense an athletic stunt. As a stunt it is good but it may not be of any use for many leg amputees. A leg amputee, if he is to be without his prothesis and move about for any distance could use crutches. For the few feet an amputee may hop a slower hop would suffice. On the whole it is a well-written and illustrated booklet and may very well be used as a guide for Corrective Therapists and other professional people working with leg amputees.

*AMBULATION: Physical Rehabilitation for Crutch Walkers*—by KENNETH A. DENING, FRANK S. DEYOE, and ALFRED B. ELLISON, corrective therapists of the Cushing V. A. Hospital, Framingham, Mass. Published by Funk & Wagnalls Company, 153 East 24th Street, New York, N. Y.

This new book makes available to the civilian handicapped or to the unsupervised paraplegic or paraparetic, the techniques and training used in one successful veterans' rehabilitation project.

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The book is also invaluable to the disabled or paralyzed person, to the psychologists or physiotherapists who work with him. The material has been gathered from medical literature not usually available to the patient, and from the *actual clinical experience* of the authors.

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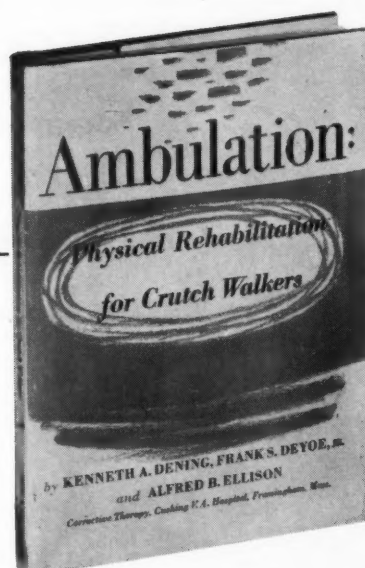
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For the lay instructor, Ambulation offers a guide and important notes on how to assist the disabled and teach the various activities.

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by Kenneth A. Dening, Frank S. Deyoe, Jr.  
and Alfred B. Ellison, Corrective Therapy,  
Cushing V.A. Hospital, Framingham, Mass.

**TABLE OF CONTENTS** — Introduction • Instructor's Information • Bed Activities • Wheelchair Activities • Mat Exercises • Preliminary Ambulation Training • Crutch Gaits • Changing Direction and Going Through Doorways • Ramps • Stairs • Curbs • Chairs • Automobiles • Moving Up and Down from the Floor • Bibliography • Index

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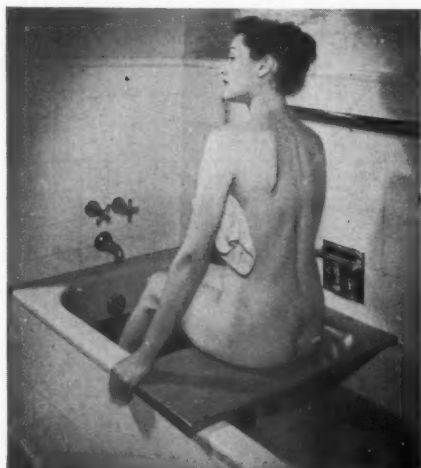
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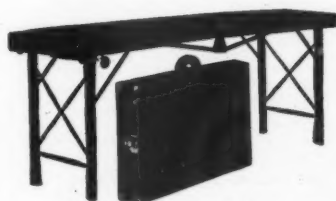
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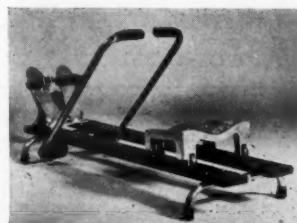
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